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Title:
Perceptions of the relationship between self-assessment and ethical decision-making in community nursing

Perceptions of the Relationship between Self-Assessment and Ethical Decision-Making in Community Nursing.

A qualitative exploration of Community Nurse's ethical processes in decision-making in clinical practice.

Jane Fitzpatrick

A dissertation submitted to the University of Bristol in Accordance with the degree of Doctorate in Education in the faculty of Graduate Education October 2002

Abstract

This study arose from my interest in self-assessment as a tool to prompt critical reflection on Community Nurses ethical awareness. The current health care climate demands that Community Nurses address a plethora of agendas for change. Rapid developments in the administration of complex care in the home and an increasing emphasis on public health initiatives are informed by different ethical principles than those nurses are traditionally exposed to. This exploratory study therefore sought to discover how Community Nurses conceptualise and operationalise the concepts of self-assessment and ethics.

The research design took into account the power dynamics within the research relationship, and therefore innovated within a postmodern approach. This however, is tempered by the prior experience of both the participants and myself since we are situated in an environment that privileges a positivist approach to knowledge and research. The presentation of the study therefore emphasises the development of the research process. This includes a critical review of the difficulties encountered in attempting to use a postmodernist approach when working with respondents.

In order to generate new ideas and establish a forum for authenticating the data a sequential approach to focus groups was developed. They were designed to enable the development of a climate of trust and a culture in which to share their thoughts about the concepts being discussed. They also allowed the affirmation of the emerging themes.

In the spirit of postmodern inquiry, this study engages participants in the analysis of their views on the topics of study. The dialogue suggests that the respondents have a clear commitment to optimising their clients' care and use self-assessment extensively in evaluating their decisions. The respondents grapple with a range of ethical issues, but their dialogue does not include ethical terminology. This suggests that within the complex health care arena, in which diverse agendas proliferate, Community Nurses may be disadvantaged in arguing their perspectives on care.

The text concludes by suggesting that further research is required to explore how both academic staff and students can contribute to raising the profile of ethical awareness within Community Nursing.

Dedication

This study is dedicated to my mother Jane. Her encouragement and support has always been an inspiration.

Acknowledgements

I gratefully acknowledge the expertise, advice and friendship of Tim Bond who has supported me in my tortuous quest in grappling with a postmodern approach to research. His critical prompting has made me extend my horizons and stick with it!

My sincere thanks is also offered to the respondents who participated in the study. Their enthusiasm, encouragement and supportive challenge has made this a very interesting and thought provoking experience.

A special thanks to Wili Ako with whom I have had many interesting discussions about the nature and purpose of research. His friendship, forbearance and support especially when I have been floundering in a sea of data and wondering how to make sense of it is especially appreciated.

The support of library staff both at the University of Bristol and at the University of the West of England is also much appreciated. Librarians, of both institutions, have been very patient with me in retrieving material from sources far and near. Their commitment and advice has been of immense help in enabling me to obtain material.

Thanks also to my colleagues at the University of the West of England who in their various ways enabled me to conduct the study. I am particularly grateful to Dr Aillee Miller who encouraged me to undertake the Ed D. and proof read my draft thesis.

Last and not least I am grateful to members of my family who have quietly supported me as they have accompanied me along my journey as the 'eternal student'.

Declaration

I declare that the work in this thesis was carried out in accordance with the Regulations of the University of Bristol. The work is original except where indicated by special reference in the text and no part of the thesis has been submitted for any other degree.

Any views expressed in the thesis are those of the author and in no way represent those of the University of Bristol.

The thesis has not been presented to any other University for examination in the United Kingdom or overseas.

Signed.....Jane FitzPatrick.....

Date.....14.:.02.:.2003.....

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1 Chapter 1: Introduction and background to the study

1.1 Introduction

This study explores the nature of the relationship between self-assessment and the ethical frameworks informing Community Nurses' decision-making in practice. The thesis seeks to redress the lack of literature and research on self-assessment associated with the development of ethical awareness.

This chapter introduces the nature of the study in order to give the reader an insight into the context, key issues and problems in developing and sustaining an ethical and critical approach to clinical decision-making in Community Nursing practice. The discussion will introduce the concepts of self-assessment, professional practice in Community Nursing, decision-making and ethical frameworks, which will inform the development of the study. In addition, the research problem and its aims are presented, together with a brief rationale for the research approach.

1.2 Background to the Study

I have developed a self-assessment initiative within a module, Working With People (for detail of the WWP module please see appendix 1) of a Community Health Care Nursing (CHCN) honours degree course. This has provoked in me, and within the teaching team questions about the efficacy of using self-assessment within a 'traditional' Higher Education (HE) culture. As a teacher and researcher involved in curriculum development, I have therefore developed an interest in evaluating the impact of self-assessment on the student experience and on their future professional practice. The important aspect emerging from my experience and from the literature is

that the links between self-assessment and ethical decision-making in Community Nursing practice require further systematic exploration.

Community Nurses are faced with several challenges within the contemporary health care agendas. These include:

1. Greater responsibility for the delivery of service which is being redefined to include the management of complex care in the home in tandem with public health agendas including health needs assessments, population profiling and health promotion,

2. Engaging with others from a range of professional, voluntary and informal sectors in designing and delivering care packages,

3. Working alone in client encounters in situations which require complex decision-making in situ, and

4. When working as team leaders they are accountable for delegating to others, with or without qualifications, who deliver care in clients' homes.

These agendas demand that the education sector address several agendas in enabling students to achieve the skills relevant to this context. These include balancing demands for:

1. Practical skills requiring technical competency,

2. Theoretical skills focused on academic understanding and insight, and

3. Critical self-awareness which infers the capacity to exercise personal

responsibility in complex and unpredictable settings.

The latter, critical self-awareness includes the capacity to think and act ethically. The study therefore offers:

- A critique of the lack of current ethics teaching including an examination of the current emphasis on bio-medical ethics and unusual events,
- A review of the contribution of self-assessment to the critical review of Community Nurse's clinical practice,
- An analysis of the implications of the evidence of lack of ethical discourse emerging from the data, and
- A consideration for the development of ethical theory and practice for curriculum design in Community Nursing.

There is little literature about the nature of decision-making in Community Nursing practice although Bryans and McIntosh (1996) suggest that it is substantively different than in other fields of nursing practice. For example, they assert that the Community Nurse, unlike nurses working in hospital ward settings, has to address a range of agendas and possible outcomes in the pre-decisional stages of decision making. In addition, the emphasis in health care literature is on bio-medical ethics and what Seedhouse (1998:38) terms 'dramatic ethics' that is, profound decisions relating to specific situations. He highlights that the exemplars given within the nursing literature reflect this trend, focussing on bio-medical ethics and the types of decisions nurses face which are likely to have an immediate profound effect on the individual. Topics include contributing to care involving termination of pregnancy or discontinuation

of ventilation and the efficacy of not to resuscitate. Bridges et al., (1997) suggest a similar problem exists within General Practitioner (GP) education, in the extensive focus on the dramatic in comparison to the ethics informing routine practice and the policy arena.

There is a dearth of literature within nursing that examines the nature of the ethical frameworks operationalised in everyday practice. Seedhouse (2000) notes the continuance of this shortfall suggesting that ethics and health care practice are seen as separate domains which only occasionally overlap. Seedhouse (1998) also suggests that although ethics have become a burgeoning concern in health care environments there seems to be an inverse proportion in relation to resourcing it as an area of legitimate education. He observed over a decade ago how little space was given in health care curricula to the study of ethics (Seedhouse, 1988), this sadly continues today. In a recent review of the Community Nursing programme for which I am responsible, the sum total of time overtly allocated to 'ethics' is a four-hour period within an academic year. Similarly, 'ethics' is subsumed within the 'foundation' module within pre-registration nursing programmes with no overt reference being made to ethics within the timetable. Although colleagues argue that 'ethics' inform practice, students often report that sessions where they do encounter ethical questions are focused on topics, such as abortion and euthanasia and do not address the everyday issues of practice.

Recently, Seedhouse (2000) argues, nurses have laid claims to big ideas, such as advocacy, care, dignity, holism, research and ethics but the emphasis is on 'rhetorical assertion rather than substantial argument' (2000:9). He ventures that health care workers should address this shortfall and take up the challenge of influencing the

emerging paradigms resulting from the developing agendas in health care. The time is therefore ripe to encourage Community Nurses to examine the nature of ethics to a fuller extent and to explore how they ask critical questions of the care environment and develop their part in shaping it.

All recruits to the CHCN degree programme are First Level registered nurses wishing either to consolidate or transfer into a Community Nursing discipline. The course of study prepares them to work independently within their professional remit in community settings. As practitioners on completion of the course they require a high level of critical thinking skills and ability to reflect-in-action (Schon, 1987), as they face a myriad of complex care decisions. Bandman and Bandman (1995) suggest that reasoning, analysing the use of language and the ability to weigh evidence are fundamental to critical thinking and are crucial to developing the skills of reflection. These agendas are adopted within curriculum development in nurse education where the emphasis is on the preparation of independent, flexible and self-motivated practitioners capable of evaluating their own skill and performance (UKCC, 1986, 1990, Peach, 1999a).

Critical reflection, as described by Bradshaw (1989), is regarded as fundamental to the development of the professional nurse. Self-assessment strategies are seen as contributing to the enhancement of students' self-awareness which is defined as a key attribute of professional development (Brown, 1990). Self-assessment as a skill contributing to both critical reflection and the development of the self-aware practitioner is therefore espoused as positively influencing the quality of nursing care (Rawlinson, 1990). Boud (1995, 1999) and Cowan (1998, 1999) affirm these

assertions purporting that self-assessment enhances these types of skills, in particular, the development of critical thinking and analytical skills.

Although these initiatives may be laudable, a review of the literature suggests that the philosophical tenants that inform them have not been adequately explored. In addition, they may run contrary to the value systems informing Community Nursing education programmes. This study therefore seeks to examine how self-assessment affects the ways in which Community Nurses critically review and analyse their ethical choices in decision-making. By engaging in these debates this study may contribute to the future development of educational programmes.

1.3 The contexts informing the development of Community Nursing programmes: The influence of Higher Education and Health Care environments

In 1963, Stuart Mill contended that:

> The university is not a place of professional education. Universities are not intended to teach the knowledge required to fit men for some special mode of gaining their livelihood. Men are men before they are lawyers or physicians or merchants or manufacturers: and if you make them capable and sensible men, they make themselves capable and sensible lawyers or physicians
>
> (Stuart Mill, 1963: 312-313)

HE's mission was the production of a cultivated elite (Neal, 1998). Even as recently as the 1980s only seven in a thousand of the population entered HE in the UK. Although this profile has changed, due to economic and social developments, Neal (1998) argues that this elite model of the university has survived, albeit in a modified form. She suggests that the ideologies associated with it continue to permeate the

discourses associated with HE.

The HE sector is however wrestling with a shift in underpinning beliefs informing its project. It now seeks to achieve and manage mass attendance of the population, 50% in England or even universal at over 75% in Scotland (Land, 2001). Although these targets are perhaps over ambitious and have not yet been achieved (Tysome, 2002), they have resulted in a review of the efficacy of liberal notions of education as a means to widen the horizons of the privileged few. These agendas have occurred in part in response to demands from industry for competent highly skilled workers (Dearing, 1998).

For nursing the demand has been informed by professionalization agendas and this is reflected in the transfer of UK nursing programmes into HE establishments (Davies, 1995). However, the emphasis on the development of a highly skilled professional, competent to work in a highly complex care environment does not sit well with Mills' notion of 'sensible men' as a precursor for professional practice. It suggests in contrast, that the programme of study should prepare the student for the world of practice. In addition, professional nursing programmes are increasing recruitment in response to a massive increase in the demand for nursing practitioners. They are required to be competent to work within an increasingly complex and continuously changing health care environment at a time when there is a projected skills shortage (DOH, 1998, Warner et al., 1998). The programme therefore requires a more vocational focus and its purpose becomes one of enabling a wide range and volume of students to prepare for the particular field of practice. Both these factors impact on the way in which the programme can be designed and assessed.

1.4 Tensions, client focus versus strategic planning: implications for ethical orientation

The range of skills demanded of Community Nursing recruits is changing rapidly. Whilst continuing to deliver client care they are now moving into agendas of leadership and strategic planning (Malin et al., 1999). This requires the development of skills, such as using and managing data collected and collated by means of computer assisted technology. Other agendas such as the development of Primary Care Trusts require Community Nurses to become more assertive and to develop leadership skills within strategic planning and Health Needs Assessment agendas (DOH, 1998). In the context of the direct delivery of care, Community Nurses demand skills in assessment, delegation, negotiation and knowledge of a range of client centered interventions. Earlier discharge from the hospital setting means that clients require higher levels of and more complex intervention in the community setting (Blackie, 1998, Symonds and Kelly, 1998, Williams, 2000). Community Children's Nurses (CCN), for example, cater for children undergoing long-term oxygen and intravenous therapies at home. In the past, these children received treatment in acute hospital wards. This move to care in the home demands different and arguably, more complex skills, such as risk assessment and teaching and assessing family members' competencies in administering care (Richardson, 1996). The Community Nurse is ultimately responsible for ensuring that the procedures and care given in the home are carried out in as safe a manner as possible. Unlike in the hospital setting, however, they are not on site to oversee the administration of care. This requires a different sort of relationship with the child, family and carers.

Kemshall (2002) asserts that, the ethical principles health care workers are required to draw upon are changing in emphasis as a result of shifts in the political climate.

Blackie (1998) implies similar concerns, referring to the changing culture in which District Nurses (DN) are required to consider the wider context of client care. They now have to extend their perspective rather than maintaining their focus on the individual client and specific interventions such as surgical dressings. For example, the initial client assessment includes consideration of the wider implications of the care environment including the carers' needs. Community Nurses now also contribute to strategic planning and service development agendas. Such requirements are informed by changes in emphasis resulting from community care policy and the rationalization of health service delivery. These are reflected in legislation, such as the NHS and Community Care Act (1990), the Carers Act (1995) and the Audit Commission's review of District Nursing (1999) and the NHS Modern and Dependable (DOH, 1998). Arguably, these changes in emphasis necessitate a different focus in ethical decision-making.

1.5 Agendas in accountability

In addition to the development of the range of skills required today, nursing has seen the advent of agendas in accountability in which professional judgement is a core activity of the professional nurse. As a professional, the onus is on the individual to promote nursing care in a manner which, protects and enhances the standing of the nursing profession (UKCC, 1986, 1990, 1992b, Peach, 1999b). Changes have therefore ensued with respect to the range of academic and practice orientated skills required of nursing practitioners.

These agendas require students on the completion of courses to be:

- Technically competent practitioners,

- Competent in a range of skills, such as resource management, leadership and managing client care,
- Equipped with transferable skills,
- Able to critically evaluate the nature of the care environment, and
- Able to adapt to a continually changing environment.

The education provider is therefore, required to prepare increasingly large numbers of practitioners, who can cope in a continuously changing environment. A protocol for the ratio of nurse teachers to students is recommended by the English National Board for Nursing Midwifery and Health Visiting (ENB). However, during the last decade nursing has seen a downsizing of staff in practice accredited with nursing and teaching qualifications. As colleges of nursing have merged and joined HE nurse educators have been perceived as distancing themselves from practice. In addition subject specialists, such as sociologists and psychologists have begun to contribute to nursing programs (Davies, 1995, 2000). This dynamic has arguably affected the professional voice brought to discussion about curriculum design since, as Eraut (1994) suggests, practice knowledge is seen to be inferior to academic knowledge within HE institutions.

These tensions result in wide ranging debates about the nature of curriculum requirements of Community Nursing programmes. Some faculty members however, continue to place the emphasis on curriculum content. In contrast, others advocate enabling students to develop skills, such as information retrieval and leadership in order to equip them to cope with the plethora of situations facing them within an

environment of continuous change (Williams, 2000).

Community Nurses often work in isolation in situations demanding skills in making complex care decisions. These decisions encompass a range of ethical positions. These may not be overt and are often made in situ, without opportunity for immediate reference to professional colleagues. This demands that practitioners can critically evaluate their contributions to the care environment and the impact of their decisions on individuals and families. In contemporary health care settings, they also increasingly contribute to strategic planning and in inter-professional agendas where they are required to articulate their rationale for their decisions to other professional groups. However, as Malin at al., (1999) observe their value base differs from that of other professional groups. If, as Seedhouse (1998, 2000) argues, nurses are not equipped with the skills of ethical debate they will be disadvantaged in articulating their perspectives on the nature and efficacy of care.

These issues lead to one of the core questions troubling nurse education providers: How does the learning environment contribute to the practitioner's ability to develop and maintain the skills and confidence required within this complex continuously changing health care climate?

1.6 Self-assessment as an option for developing critical thinking

Brew (1999) asserts that involving students in their own assessment is increasing in HE agendas. This move is prompted by calls to develop the 'lifelong learner' and a sense of the 'autonomous' learner promoted by reports, such as the Dearing Report (1998). Within nursing these calls are echoed in the UKCC Commission for Education and Practice (Peach, 1999a) and in the ENB's emphasis on initiatives to

develop the reflective practitioner to enhance competency in the workplace (ENB, 1993, 1996b, Quinn, 2000). However, as Brew (1999) observes, within the literature self and peer assessment are talked of simultaneously as if they set out to achieve the same goals with scant regard to the theoretical precepts underpinning them. They have different consequences for the individual, for example, in the manner in which power and authority are shared, control is shared and the student is encouraged to develop the skills of independent and autonomous judgement.

Boud and Felletti (1991) have suggested that the defining characteristic of self-assessment is in the involvement of students in identifying standards and/or criteria to apply to their work. The process includes making judgements about the extent to which they have met these criteria and standards. Boud (1995) also asserts that in order to develop a level of skill in undertaking self-assessment, students need to develop the skill as they progress through their course. In addition, Brew (1999) suggests that the ability to self-assess effectively does not happen on its own but is a skill developed through structured practice and is reinforced by feedback on the ability to undertake the activity. The ENB (1993, 1996b) confirm this assertion suggesting, that such initiatives must be seen as integral to the programme of study in order to encourage students to articulate the interplay between theory and practice. However, they also observe that this philosophy emerges where the education environment works as a cohesive team rather than in one where subject specialism and separateness continue to dominate the agenda. Boud (1999) affirms this assertion suggesting that academics need to review their own practice and model self-assessment 'in our own practice as a teaching profession' (1999:129). He goes on to state that academics must engage on a deeper level with others and cautions against

the separatism which conventions of academic practice have encouraged, if we are to develop a reflexive and collaborative culture. These are in his view important considerations if we are to encourage these attributes in our learning environments.

Within professional courses, there is an impression that self-asscssment is a legitimate aspect of the assessment process in practice, however, it has limited status within the academic aspect. A recent review of self–assessment within academic modules, offered to nursing students at the University of the West of England, revealed that only one overtly included an element of self-assessment in which the students were able to engage in the judgement about their achievements (Fitzpatrick, 2001). A tension therefore, arises between self-assessment in practice, in contrast to its perceived legitimacy in academic subjects.

1.7 The position in established practice.

The literature examining the impact of self-assessment within the context of educational programmes does not address its effect on established practice. Within nursing there are a range of policy statements including Vision for the Future (1994) and UKCC (Peach, 1999a) suggesting that practitioners need to develop a critical approach to practice. In addition, there are a raft of initiatives following the Dearing Report (1998) and UKCC statements (UKCC, 1986, 1990, Peach, 1999a) espousing the concept of lifelong learning. Mechanisms to support these developments include initiatives, such as clinical supervision in which practitioners are encouraged to share experiences and review their practice. However, there is little debate about how these opportunities influence the practitioner's approach to clinical decision-making.

Colleagues in practice suggest that the care environment in which Community Nurses

work is complex and demands a high level of critical thinking. This view is supported by a review of the professional literature (Bryans and McIntosh, 1996, Jones, 1996, Davies et al., 2000, Williams, 2000). It is also suggested that it requires extensive expertise in the management of care delivery. What is unclear is what informs the manner in which Community Nurses view and apply ethical principles when making the care decisions required of them.

1.8 The research problem

It is unclear from the literature whether skills developed by engaging with the principles of self-assessment affect the practitioner's practice or if they are sustained in the longer term. Within the UK literature, whilst some regard is given to aspects of ethical practice relating to duties and obligations, little is written about the professional's development of his/her own ethical conceptual framework or his/her application in practice. It is unclear from the literature how, in a rapidly changing context, Community Nurses reflect on and apply ethical principles. This study therefore, seeks to explore whether self-assessment in itself has an ethical component and if self-assessment contributes to the analysis of ethical dilemmas within practice.

1.9 The approach to the research

The research seeks to explore Community Nurses' perceptions of the concepts of self-assessment, ethical principles and decision-making applied in practice and is therefore conducted as an exploratory inductive study. A postmodernist approach was chosen since it emphasizes the need for the researcher to be reflexive, engage with the respondents in a collaborative manner, to authenticate the interpretation of data and to deconstruct texts surrounding the issues presented. In developing the research design,

I decided to use a sequential approach in the use of focus groups in order to

develop opportunity for collaboration, development of ideas, witnessing and authentication of the data.

The postmodern perspective also stresses the 'plural, fragmentary and subjective nature of reality and of the self' (Lister, 1997:41). This approach would therefore seem to lend itself to the topic of study given the topic and context.

The study reviews the difficulties encountered in sustaining a postmodern approach in conducting empirical work. It offers a reflexive account of the decisions made in adopting a more 'traditional' approach to the data analysis as a consequence of these issues.

1.9.1 Aims of the study

This study therefore seeks to explore:

- Community Nursing practitioners' perceptions of self-assessment and its efficacy,
- Current practice of self-assessment,
- The relationship between self-assessment and Community Nurses' skills in clinical decision-making,
- The ethical frameworks clinical practitioners operationalise in practice,
- The links, if any, between Community Nurses practice of self-assessment and their conceptualisation and use of ethical frameworks, and
- The impact of the research relationship on the development of the study.

1.9.2 Rationale and significance of the study

The reasons for the study are:

- Principally lack of attention to self-assessment as relevant to or sustained in professional practice,

- Lack of literature about how nurses engage with ethical frameworks informing everyday practice'

- To establish if Community Nurses perceive and/ or demonstrate any link between SA and their use of ethical frameworks,

- Significance in informing the development of educational programmes which affect the development of the relevant skills, and

- To explore the dynamics of conducting a research project within the spirit of a postmodernist philosophy.

1.10 Structure of the study

This first chapter presents an overview of the key issues and problems that stimulated the development of this study

Chapter two offers a rationale for a cyclical approach to reviewing the literature. It critiques the relevant literature that supports the theoretical orientation of the research question. The key themes discussed emerged both from the literature and from terminology used by practitioners in the focus group discussions. These serve to focus the writer's attention on concepts which might enable illumination of key dilemmas and practices evident in Community Nursing contexts.

Chapter three discusses the rationale for the research design and research methodology. It contextualises the choice of a postmodern methodology and argues

the case for a collaborative approach in conducting research.

Chapter four discusses the process of the data analysis. This includes a critical evaluation of the dilemmas encountered in attempting to analyse the respondents texts whilst attempting to maintain a commitment to a postmodernist approach. It outlines the steps of the process of data analysis and explains the use of Strauss and Corbins' (1998) model of interpreting qualitative data. It then justifies the use of a Computer Assisted Data Analysis Package (QUADAS) in confirming and extending the interpretation. The package used was NUD*IST. It also offers a rationale for using a multi-level framework in elaborating on the analysis.

Chapter five presents the themes which emerged from the focus group discussions, and is grouped under the following headings:

- Assessment and self-assessment, associated with:
  - Risk, confidence and support.
- Agendas affecting decision-making,
- Ethical constructs of autonomy, reciprocity and integrity.

It seeks to link the themes described by the respondents with the wider substantive and theoretical issues, whilst respecting their particular experience.

Chapter six presents a discussion of the significance of the emerging themes for developing Community Nurses who are cognizant of issues informing their ethical frameworks. Whilst mindful of the postmodernist reluctance to engage with claims to

truth, it offers the respondents perceptions of issues worthy of further consideration and research

Chapter seven offers a review of themes which emerge from the study. Whilst mindful of thc limitations of the research approach it considers the implications these may have for the development of curricula design in Community Nursing programmes. It also makes suggestions for further research enquiry in this area.

Figure 1 below illustrates the main structure of the dissertation

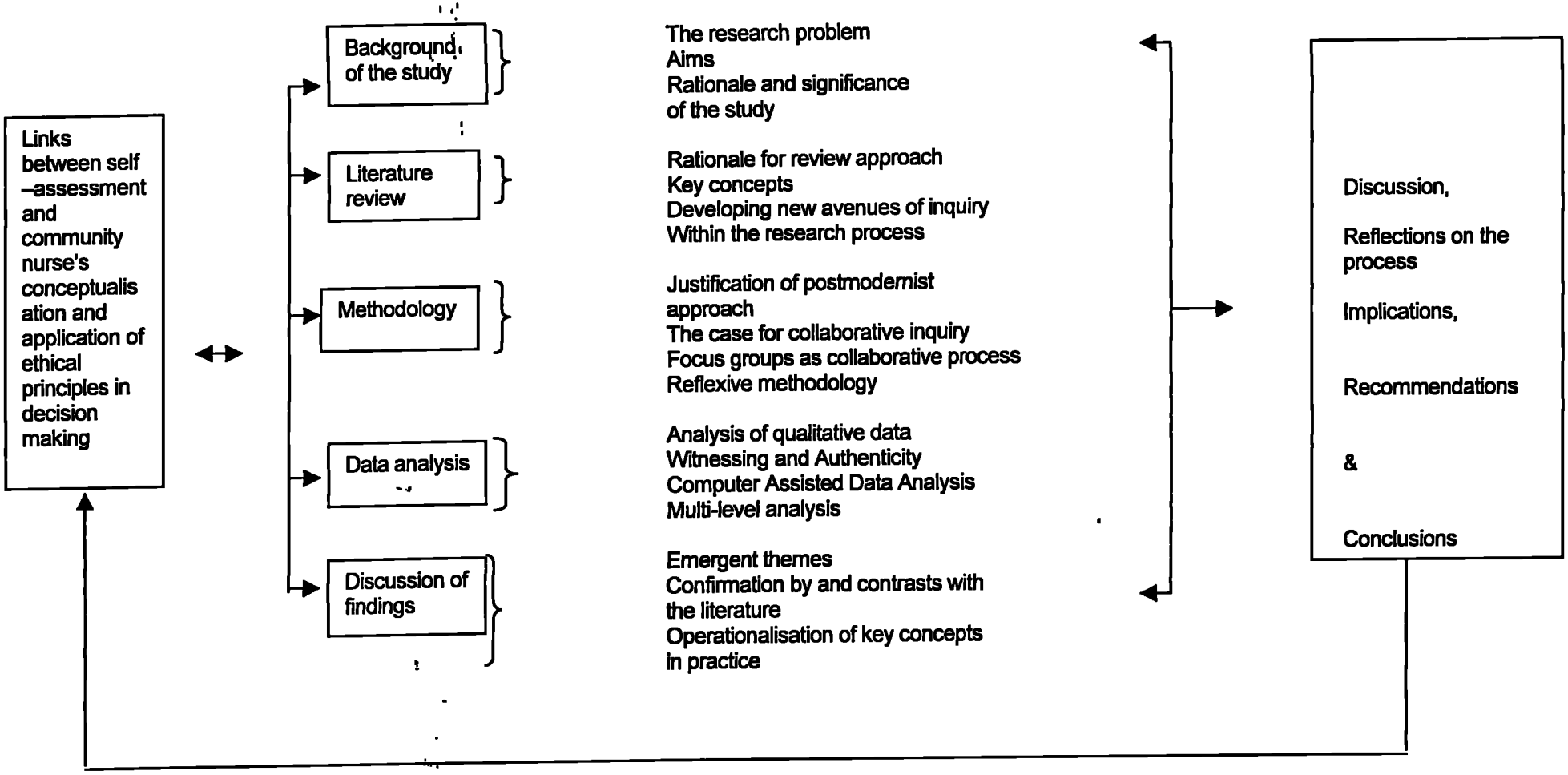


Figure 1:The structure of the dissertation

2 Chapter 2: Literature Review

2.1 Introduction

There are many terms used to describe the process of identifying, retrieving and analysing published works informing a research endeavour (Cooper, 1998). The broadest term is literature review. This typically appears as an independent work or as a brief introduction to new research reports. Cooper (1998) argues that they can also inform research outcomes and methods and methodologies as well as the theoretical analysis and application of the data analysis. Thus, they can be used as an integrative process to analyse previous work, to produce links between subject areas and to identify central issues in a field of study.

This literature review falls within the latter category and aims to:

- Provide a rationale for the research process including choice of methods and methodology,
- Identify key literature in the relevant fields,
- Contribute to the generation and pursuit of new avenues of inquiry arising from the data, and
- Act as a focus from which to compare and contrast the data generated in this study with other findings.

The first item substantively informs the methods chapters whilst the fourth informs the data analysis section. Items two and three provide the focus for this chapter which

describes the rationale for the approach to the literature review, including the relationship between the fieldwork and the development of avenues of inquiry within the literature. Given the exploratory nature of this study, concepts generated from the literature inform the initial theoretical orientation and complement the analysis of concepts as they emerged from the fieldwork. The discussion reviews the literature on self-assessment, the nature of professional practice in nursing, decision-making and ethical frameworks informing nursing practice, which provided the focus of the initial question. It examines how the discourse evidenced in the literature reflects the concepts of risk assessment and integrity that were important themes emerging from the focus group discussions. Thus, the literature review becomes an integral part of the research process and new ideas worthy of further exploration comprise a crucial component of the research process (Punch, 1998).

2.2 Rationale and framework for the literature review

As a novice within the postmodernist research paradigm, I felt that I needed to structure the literature review in a way which would lend itself to reviewing and interrogating the literature according to the philosophy of this methodology. The commitment to addressing the power dynamics inherent within the research relationship meant working in a collaborative manner with the respondents in designing the project, authenticating, and interpreting the data. The intention to interrogate the process and data from a postmodernist perspective included analysing the text(s) not only as a descriptive account but also by considering the possibility of multiple meanings and interpretations dependent on context and perspective.

Hart (1998) argues that generating all of the literature review prior to the commencement of the fieldwork enables the researcher to have a complete sense of the knowledge of and history of the field. However, according to Strauss and Corbin (1998), this approach pre-empts opportunities for seeking a new perspective on the research questions. Both paradigms also affirm the legitimacy of truth claims, an assumption that runs contrary to the postmodernist assertion that there is a decline of absolutes (Usher et al., 1997). This does not imply however that the research process should not be systematically conducted, but that the process itself should be scrutinized for inherent assumptions that are often unacknowledged.

The review process needed to promote opportunities to address the power dynamics within the research process and allow for new avenues of inquiry. It also needed to accommodate the critical analysis of the discourse found in the literature and that emerging from the focus group discussions. Strauss and Corbin's (1998) model for analysis of ethnographic data seemed a reasonable starting point. According to Punch (1998), the postmodernist perspective does not imply a rejection of all research methods but rather suggests a questioning and doubting of all methods. In essence, one should question all methods that privilege authoritative forms of knowledge. Although the model derives from a modernist tradition, it seemed that it might be used in a flexible way that would allow for the generation of ideas from the research process. It would also accommodate a critical interrogation of the literature review and research data. Alvesson and Skoldberg (2000) draw our attention to the limitations of modernist approaches in which the data may not be critically interrogated. In my view however, this might result from the researcher's philosophical perspective rather than the model itself. Albeit

models reflect a particular philosophical stance and set of assumptions, arguably they also provide a framework on which to hang ideas and may provide a starting point for critical analysis (Aggleton and Chalmers, 2000).

In order to familiarize myself with the collaborative and critical inquiry aspects of the review, I drew on principles described in the postmodernist literature. This meant becoming more aware of knowledge claims or what Usher et al., (1997) describe as 'the socio-cultural contexts, unacknowledged values, tacit discourses and interpretative traditions' (1997:207) informing the literature review and research process.

As Strauss and Corbin (1998) argue, the researcher brings to the research inquiry a considerable background in professional and disciplinary literature. The background is often acquired whilst studying for professional examinations, or whilst keeping up-to-date in the field. During the research process itself the researcher goes on to uncover a plethora of material through literature reviews, personal contacts and other sources which are felt to be pertinent to the field of study. The question becomes one of deciding on how to best use this information in a way that enhances rather than constrains the theory development. One cannot therefore review all the literature before commencing the fieldwork since it is impossible to know what the problems will be, or what theoretical concepts will emerge.

Strauss and Corbin (1998) suggest that the literature review informs the development and analysis of data within the qualitative paradigm. Aspects they raise which are relevant to the current study include:

1. *Providing a source of comparison to data on a dimensional level,*

2. *Establishing familiarity with the relevant literature, which can enhance sensitivity to subtle nuances in data. The balance is to decide if the themes are emerging from the data or if the researcher is so familiar with those themes that they are seeing them because of prior experience,*

3. *Providing a source to stimulate questions as an initial starting point during initial observations and interviews, this serves to both inform the project and to provide justification to ethics committees and other agencies about the efficacy of the project,*

4. *Providing stimulation for questions during the analysis process,*

5. *Using the literature to confirm findings, or conversely the data can be used to illustrate discrepancies between the literature and experience.*

(Adapted from Strauss and Corbin 1998:49).

Strauss and Corbin (1998) do not address the issue of socialization that occurs as a result of the professional and disciplinary exposure to the subject area. This became an issue for me as I started to interrogate my use of language. In using the postmodernist approach one is expected to critically review one's stance and assumptions resulting from one's personal trajectory (Gubrium and Holstien, 2000).

In order to address the postmodernist perspective, some of the literature was generated in response to the respondents' contributions in the spirit of addressing the power dynamics within the research relationship. Also an attempt has been made to interrogate the texts according to the context of their production and the assumptions held within the respective fields.

Following Strauss and Corbin's (1998) exemplar, this research project evolved from my interest in self-assessment and professional decision-making. My interest in self-assessment had begun some years ago whilst undertaking my Post-Graduate Certificate in the Education of Adults. My current role in HE had enabled me to take this interest further on two fronts, firstly, in introducing self-assessment into a Community Nursing course, and secondly as an extension of the Self-Assessment in Higher Education Project (Fitzpatrick, 2001). This latter project involved a review of self-assessment initiatives within my faculty. I therefore had some background knowledge of these areas. However, I was less familiar with the literature informing other aspects of the study, such as the nature of ethical principles.

A further consideration arose from a personal need to be acquainted with the literature on ethics sufficient to enable me to follow the threads of the arguments presented by members of the focus group. This was in order to capture and extend the discussion in situ as the discussion unfolded. If as Dracopoulou (1998b) argues, professions are underpinned by ethical principles one would assume that this had been a core concern throughout my training and education. However, although throughout my career I have been confronted with ethical questions, I had had no formal exposure to discussions on ethical perspectives in the wider sense other than that within the Ed.D and in the context of research training. This experience mirrors Seedhouse's (1998) observations of the lack of time and commitment afforded to ethics within health care curricula. My desire to engage with this literature was associated with a need to feel confident in guiding the discussions without undue bias resulting from my personal understanding of ethics.

A key aspect of the initial trawl of the literature was to establish the nature of the available literature, which would inform the development of the questions and the research process. It was imperative to have sufficient evidence from the literature to suggest that the topic was worthy of further study. It was also important to have a knowledge of the relevant literature with respect to the concepts to be studied and the methodological orientation in order to submit my proposal to faculty and university ethics committees (Strauss and Corbin, 1998). In conducting this aspect of the review, I was mindful of the traditions within the university and the need to clearly justify the postmodernist approach, the nature of my engagement with former students as well as the topics of study. This was in order to pre-empt sanctions by the institution. Failure to do so would have meant that the proposal for the project would have had to be revisited and this would have had an impact on the design and time-scale for the fieldwork. This is a major consideration given the nature of the study, the availability of the respondents and the commitments of the researcher. This was important since the research was deviating from the positivist tradition which Neal (1998) and Usher et al., (1997), suggest dominates the HE research agenda.

The initial review of the literature also contributed to the decision to refine the study and start with a more basic approach than first proposed. In part this was due to the realization that the dominant themes within the literature on ethics tended to refer to case examples and unusual events, often with a bio-medical focus (Burnard and Chapman, 1993, Tschudin, 1993, Edwards, 1996). There also appeared to be a tacit assumption that a rational model of decision-making as evidenced in the nursing process might adequately enable a nurse to address ethical issues. Some authors such as Thompson et

al., (2000) acknowledge the tension inherent in the dynamic context of nursing and allude to differences across cultures. However, they continue to place emphasis on the principles of avoidance of harm and a sense of inherent 'good' rather than addressing issues of difference. They advocate enabling nurses to explore the implications of ethics but do not address the range of ethical perspectives that inform the contemporary health care environment. Seedhouse (2000) suggests that the preoccupation with unusual events within the bio-medical domain uncover only the tip of the iceberg. He describes the emphasis on what he describes as 'hot spots' or dramatic occurrences as negating the complexity of general moral and ethical principles informing the everyday world of practice. The study therefore sought to explore the discourse Community Nurses use in describing ethical issues in order to consider the significance of their use of language.

As the review unfolded it was apparent that there was very little literature about how Community Nurses make decisions. Lister (1997) argues that in its mission to gain academic credibility nursing has adopted a highly rational discourse. This parallels the dominance of rational and scientific aspects of the medical profession. The nursing process which is advocated as informing 'good' nursing practice, and in consequence decision-making, is derived from this rational perspective. However, Bryans and McIntosh (1996) argue that this way of approaching nursing practice does not comprehensively address the complexity of decision-making in Community Nursing practice. They suggest that in the world of Community Nursing, decisions do not necessarily follow a rational model.

In order to explore the application of ethical principles, the review was conducted as a cyclical process in which the literature informed the research process and the process

informed the review. This included contributions from the respondents, reflection and initial data analysis that pointed to new avenues to explore in the literature. For example, the respondents made reference to risk assessment that had not been an obvious avenue of inquiry but had dramatic impact on the Community Nurses contemporary practice.

2.3 Complex concepts conceptualizing and operationalizing the research problem

The three concepts of self-assessment, decision-making and ethical frameworks, which were pivotal in initiating this study, proved to be problematic to operationalize. For example, self-assessment is associated with a range of ideas around the notions of both self and assessment. It is discussed therefore, under three sub-headings of assessment, self and self-assessment. The discussion then examines conceptualization of self-assessment within professional education and nurse education settings. The analysis draws attention to the tensions inherent in situating professional nursing courses within a HE setting. It attempts to draw parallels between theories of self and identity and the professional project in nursing and relates this to the ethical frameworks relevant to Community Nursing practice.

2.4 Assessment strategies

As Broadfoot (1999) asserts, assessment is a dangerously ambiguous concept since it can be used for many different ends. For example, assessment results are increasingly used as performance indicators as well as some indication of a student's level of achievement. Hinnet and Thomas (1999) invoke similar concerns in the context of vocational education when they assert that assessment serves:

> pedagogic, political and economic functions which result in students achieving certification relating to the context in which they are preparing to practice.
>
> (Hinnet and Thomas, 1999:7)

This infers that assessment agendas serve not only those of the assessment of the individual's achievement but also a range of other interests. This relationship is complex and in nursing contexts, Peach (1999a) contends, it is imbued with concerns, such as protecting the public as well as judging individual performance.

The emphasis on technical rationality, which pervades the HE assessment agenda is derived from a positivist tradition (Schon, 1987). This standpoint is however problematic since it does not equate with what Schön describes as a world of 'situations of indeterminacy and value conflict' (1983:17) which inform vocational contexts.

Despite the apparent conflict surrounding assessment agendas in HE, between standardization and the development of learning, self-assessment is proffered in the literature as a means of enhancing critical thinking (Cowan, 1998, Boud, 1999). Within nursing, it is also associated with the development of clinical practice and the call for a reflective practitioner who can adapt to Schön's (1987) world of uncertainty and potential conflict. However, the notions of self as well as that of assessment are not conceptually clarified in the literature relating to self-assessment. Although within practice orientated aspects of programmes there is evidence that it forms an important part of the assessment process, it was difficult to uncover how the notion of self-assessment is operationalised.

There are many models of self-assessment and the term holds a range of meanings for different individuals and groups. However, any suggestion that it can inform summative assessment continues to be as problematic. Rowntree (1977) in his seminal work on assessment raised some of the issues associated with practices in self-assessment which still have relevance in today's contemporary professional context. For example, he urges us to examine the purpose of assessment and draws our attention to the need for the student to become a critical judge of his or her own performance. He urges teachers to:

> turn the definition of it *(assessment)* in upon itself and think about the person (*student or teacher*) finding out about himself – self-assessment
>
> (Rowntree, 1977:4).

Rowntree argues that if the student can become capable of working for his own satisfaction he or she must become responsible for his or her own feed-back. This sense of self-assessment seems to emerge from the humanistic tradition and the strife for individual autonomy.

2.5 Theorising self

St. Pierre (1997:279) following Flax (1990), cautions us to be critical of the humanist tradition. She argues that it reflects an image of the 'stable coherent self' and which assumes that language is transparent and that reason and science provide an objective reliable and universal foundation of knowledge. She bids us to question the pervasive influence of the humanistic tradition embedded in the language of education in order to build new sense and meaning outside 'the *logos* of humanism' (1997:287). Similarly, Gergen (1999) argues that the humanistic tenets informing the discourse on concepts of

self limit the opportunity to transform our understanding of self. He contends that we are in danger of losing the opportunity to review the historical and social processes that inform the development of self. He suggests that there are two perspectives giving us potentially competing agendas in determining the nature of self. In his view, the belief in individual agency forms the basis of our 'institutions of moral judgement' (Gergen, 1999:118). In contrast, he also contends that the preoccupation with the notion of self as a contained individual is fundamentally at odds with the kinds of 'social institutions which make up a viable society' (Gergen, 1999:120).

Layder (1994) affirms the complexity in analysing constructs of self and the meaning individuals invest in their individual trajectories. He illustrates the difficulty in placing the emphasis on a particular aspect of identity with reference to a range of theories. For example, referring us to Goffman's (1959, 1990) interactionalist perspective of strategies individuals use in social situations, Layder suggests that, Goffman pays only limited attention to the way in which encounters with others shape our perception of self and our subsequent behaviour. He also challenges the grounded theorists emphasis on the biographical aspects of life affecting the development of self. He reiterates this inadequacy with reference to his own research in which actors suggested that they are drawn to people who are neurotic, unstable and insecure. It is the actor's own actions which result in their social situation. In contrast, Layder suggests that acting as a career produces insecure and unstable environments which can lead to psychological vulnerability and 'seemingly neurotic forms of behaviour' (1994:77). In his view it is engagement in the situation rather than an active choice in recruiting those around one that results in the social mix of people actors engage with.

Layder (1994) suggests that we need to pay attention to what he describes as the interrelation between self-identity and the settings and contexts of social activity. He argues that we cannot discuss concepts of self without reference to events and encounters as well as the social milieu in which the individual develops their identity.

The feminist literature on gender provides an additional theme which pervades sociological studies of the professionalization project in nursing (Porter, 1992, Davies, 1995, 2000). It draws attention to the macro level and the implications of structural mechanisms affecting organizational experience. This conceptualization of self is significant to this discussion with respect to ethical decision-making since as Gilligan (1982) argues, decontextualization and detachment of self from others 'breeds moral blindness' (1982:28).

In her analysis of the professional project in nursing, Davies (1995) draws attention to gendered experience of nursing. Davies asserts that this is significant since 90% of nurses are women. Drawing on Gilligan's (1982) work, she sees the gendering of the profession giving rise to a struggle with traditionally perceived attributes of professionalism such as altruism which conflict in her view with women's accounts of selfishness. In Gilligan's (1982) view, men exhibit a different way of thinking and have a bounded sense of self early in their development. In contrast, she sees women as having a cyclical confrontation with this sense of moral values, such as privilege, altruism and connection suggesting that at times these should be challenged. This leads her to argue that there is an ethics of justice in which there is a clear sense of the person as autonomous, with duties and obligations, juxtaposed with a sense of responsibility associated with an ethics of care. In this latter framework, concern for others overrides personal autonomy. Responsibilities to

others are perceived as more important than rights and altruism less significant than self-sacrifice. The difficulty is that the masculine attributes can be seen as selfish whilst the feminine can be seen as fostering dependency and indecisiveness.

Figure 2 outlines Davies' (1995) analysis of the impact on gender on the development of identity that she sees as key to the development of the professional perspective in nursing.

Figure 2 **Cultural codes of gender**

	Masculine	*Feminine*
Development of self	Separation	Relation
	Boundedness	Connectedness
	Responsibility to self	Responsibility to others
	Self-esteem	Selflessness
	Self-love	Self-sacrifice
Cognitive orientation	Abstract rule governed thinking	Concrete contextual thinking
	Mastery/control	Understanding/use
	Emphasis on expertise	Emphasis on experience
	Skills/knowledge as portable acquisitions	Skill/knowledge as confirmed in use
Relational style	Decisive	Reflective
	Interrrogative	Accomodative
	Hierarchy orientated	Group orientated
	Loyal to subordinates	Loyal to principles
	Agentic/instrumental	Facilitative/expressive

(Source: Davies, 1995:29)

The first category, development of self, draws on Chodrow's (1978, 1989) gendered image of child development. She suggests that the male cultural code emphasizes separation, independence and autonomy. In contrast, the female cultural code implies that the project is relational and emphasizes connectedness to the mother.

The second category draws on Gilligan's (1982) work on perspectives of knowledge. The male perspective infers knowledge as abstract and rule governed and has to be mastered and possessed. Knowledge is acquired in order to fulfil an obligation to the self as expert. In contrast, the feminine perspective derives from concrete and contextual examples. Here knowledge needs to be confirmed and understood within context. Instead of a confident feeling of possession and mastery of knowledge by the self there is a need to have confirmation and validation by others.

In the third category, Davies (1995) has attempted to demonstrate the positive aspects of the feminine perspectives, for example, emphasizing the reflective and facilitative aspects of the behaviour rather than as indecisive attributes they are often perceived as.

Gender is a significant issue in health and social care. Dombeck (1997:12), for example suggests that 'very often in team situations the physician assumes the responsibility for leadership and other team members collude with this decision'. This assumes that the physician, as male, has legitimate power. Malin et al., (1999:179) also caution that gender-based inequality is evidenced within team relationships in health and social care settings. They refer to West and Field (1995) who offer evidence of male team members ignoring the contribution of female workers within teams. However, gender is not the only dimension affecting the perception of self and thus the power dynamics within health and social care contexts.

Alternative constructs of self emerging from the postmodernist literature suggest that individuals have multiple identities and are worthy of further exploration (Goodson, 1997, Usher et al., 1997, Mason, 2001). For example, Nicholson and Seidman (1995)

assert the need to contextualise constructs of identity and self with reference to socio-historical dynamics. Young (1995) contends that in order to do this we need to consider the individual within a framework of 'seriality'. This means that the individual may belong to a range of groups consecutively or sequentially but is not exclusively the member of one. The individual is no longer confined as a member of a group with defining characteristics, such as gender or social class but instead is passive in relation to a specific social milieu. According to Young (1995), this both constrains and enables action but does not define or determine them. Using this concept, the individual can define oneself according to a range of possibilities either simultaneously or serially. Thus one can be:

> a farmer, commuter and radio listener and so on together with others similarly positioned. But the definition is anonymous, and the unity of the series is amorphous, without determinate limits, attributes or intentions.
>
> (Young (1995) cited in Nicholson and Siedman, 1995:21)

This sense of self is not constrained by a particular identifier, such as gender. It allows for plurality in identity. This sense of fluidity of group membership seems to reflect the experience of students participating in the Working with People module in defining their sense of self within assessment criteria. They define their sense of self according to a range of reference points and parameters depending on the nature of the skill they are developing and the context of their lived experience at work and in their personal life.

Mason (2001) offers us an alternative explanation of self that has some parallels with Young's serial identity. He argues that in late modernity the identity of the self assumes reflexive awareness. He further suggests that in the contemporary context identity, is less

stable and more fluid than in traditional society. He refers to Giddens' (1991) sense of the 'disembedded' nature of identity associated with a diminished sense of moral responsibility. He argues that in a world of globalisation and the increasing complexity of social life our actions have consequences 'far beyond what we can imagine' (2001:48). Mason highlights that within a strongly individualistic society there is a tendency to withdraw from the sphere of public life and that this results in a reduced sense of moral responsibility to others. He goes on to suggest that the power of modern technology results in a rise in instrumental rationality and an emphasis on economical outputs and efficiency. This is significant since in his view this results in the individual giving scant regard to ' human or other moral consequences' (Mason, 2001:48).

Mason (2001) contends that the reflexive construction of self is 'considerably less determined and stable than identity in traditional society' (2001:47). This suggests that the individual sense of self is influenced by opportunities that provoke reflexive consideration of one's identity. Within health care settings in which arguably nurses are expected to engage with a sense of moral responsibility in caring for others, this is an important consideration when developing nursing curricula.

2.6 Implications of contrasting theories of self

Goodson (1995) draws our attention to the tension between theories which emphasize the personal in contrast to the those which stress the effects of the political and the influence of economic restructuring taking place in contemporary society. In order to interrogate the discourse and social construction of lived experience we need to take account of the wider socio political context. This may allow us to engage with a range of perspectives whilst remaining within the spirit of the postmodern paradigm.

Interactionalist and grounded theories offer something in the examination of the micro levels of social life. Young (1995) and Davies (1995) in contrast attempt to enable us to appreciate the effects of structural mechanisms such as gender and social class. However, all of these perspectives are fraught with conceptual difficulties and raise the issue of research as a political endeavour. For example, Davies' (1995) gendered approach can result in cries of essentialism and normalisation since there can be a tendency, in reducing phenomena to key characteristics, to misrepresent the complexity of the phenomenon. In addition, Davies' theory does not sit well with those in the academic environment. As Tronya (1994) and Neal (1998) observe, within the context of research in educational policy and in HE environments, feminist theorists find difficulty being accepted within academic environments which privilege scientific endeavour. In a similar vein, Heinrich (1999) drawing on her experiences with mid life female doctoral students suggests that women within the academic environment struggle to be heard within this domain. In my experience, many nurses may decry the association with gender declaring that this view falls outside their personal experience. A recent study of women graduates from Girton college reflected a similar view in that they do not anticipate institutional barriers arising from sexism in the workplace since they do not expect them to be there (Fream, 2002).

If we take Mason's (2001) sense of self as created and sustained within the reflexive awareness of the individual, it may be possible to review the position from the individual's perspective. It also allows us to explore the nurses disengagement with the sense of a gendered experience. However, although Davies' (1995, 2000) gendered explanation may be at odds with the individual's experience, it may provoke a discussion

focus from which to explore structural issues. Indeed if we integrate the perspectives proffered by Davies (1995, 2000), Young (1995) and Mason (2001) and argue for fluidity in experience and membership of groups the gendered analysis may provide a lens through which to compare and contrast the experience of individuals. Arguably, we do not need to strive for absolute distinctions but rather use the typology as a starting point of analysis as a basis for comparison and contrast.

As Goodson (1997) asserts, identity is an arena for struggle and definition. He suggests that the fields of:

> identity politics, the reflexive project of the self and broader social and institutional movements and missions have always been there
>
> (Goodson 1997:205)

In analysing the interrelationship between them he argues that we need to:

> look to broader patterns of data and data analysis which focus on the reflective project of the self.
>
> (Goodson, 1997:205)

One way of conceptualizing this dynamic may emerge by drawing on Layder's (1994) research map. A range of factors may influence the individual's sense of self and identity drawing on this multi-level analysis we may illuminate issues which influence an individual's experience. This allows for an exploration of the nature of individual encounters and the contexts in which the individual acts. It also permits an examination of structural factors, such as gender and social class that influence the experience. This

avoids exclusivity of theory generation on the micro level and acknowledges the relevance of intermediate and macro levels of social interaction.

2.7 Implications for the development of the ethical self

The analysis of self suggests that it is central to the conceptualization of the ethical self. A movement from a humanistic explanation and theories privileging binary oppositions such as those advocated by Thompson et al., (2000) are seen to have limited validity within contemporary society. What begins to emerge is a sense of self, which is relational and dependent on context. This shift to a relational concept of self has implications for the analysis of the ethical self.

Noddings (1984) affirms this assertion when she suggests that ethical responsibility, within an ethic of caring, is dependent on the reaction from the one being cared for. She illustrates this with reference to a conflict situation in which a daughter is caring for a parent who is cantankerous and ungrateful. Here she suggests that 'pursuit of the ethical ideal demands impassioned and realistic commitment' (1984:100). Thus affirming the suggestion that the pursuit of ethics is not an abstract endeavour, but one dependent on a dynamic interplay of interrelationships occurring within the situation. It also illustrates that ethics are embedded within the everyday events confronting those caring for others.

Thus, a relational aspect of self, extended to include our sense of ethics informs the discussion on the nature of professionalism and the implications for decision-making within Community Nursing.

2.8 The development of self-assessment strategies informing professional education agendas

The difficulties in conceptualizing the nature of self are mirrored in the debates about self-assessment as a tool to enhance self-development of learning and/or competency in professional practice. Some of these tensions arise from its situation within a HE environment. They also arise because these two aspects of self-assessment may be conceptually incompatible. This dichotomy has its roots in the debates about the purpose of assessment. Originally, self-assessment was perceived as an informal tool informing the development of learning and aligned with formative assessment. As such it has been largely ignored in terms of formal recording as an indicator of achievement and in the quest for quality assurance indicators. As contributing to assessment of competency, it is associated with a sense of measurement of ability to engage with and sustain a skill required in professional practice. This latter aspect has become part of the raft of indicators of achievement and performance indicators required in a climate of quality assurance and standardization (Peach, 1999a).

This distinction between the development of academic inquiry and skills to inform practice is important since as Eraut (1994) argues, different forms of knowledge have differential status within academic arenas. Academic or propositional knowledge is perceived to have higher status although professionals would argue that experience has more relevance in the world of practice. This tension has a direct impact on perceptions of why, what and how assessment is conducted within academic environments in which nursing programmes are situated. We therefore see self-assessment developing as an

informal tool within academic aspects of programmes whilst it contributes to the substantive assessment of practice competency.

As Boud (1999) asserts, there has been a transformation in the nature of professional education during the last two decades. There has been a recognition that professional courses must engage with professional practice. That is to say, that professional *practice* and professional *knowledge* have come to be recognized as essential agendas for the development of professional courses. Following Eraut's (1994) analysis, he suggests that the forms of knowledge - personal, process and propositional; all inform professional practice. It has slowly been recognized that such courses must address all aspects of knowledge creation, not only content. Boud (1999) argues however, that although practice *placements* have been part of courses for decades, the focus on getting the student to think professionally is new. He suggests that there is a change in focus in facilitating the process of learning-to-learn.

Academic environments concerned with the development of autonomous professional practice seem to have been attracted to the humanistic analysis of self. This tradition is concerned with notions of self-monitoring and the need for practitioners to take responsibility for upholding their own professional standards without external policing (Boud, 1999). However, theorists of self-assessment do not necessarily declare their position within a social science framework of analysis. Indeed, many seem to take a pragmatic approach based on experiential development of self-assessment initiatives within educational programmes. For example, Heron (1974) assumes that self-directing, self-monitoring and self correcting behaviours are 'the hallmark of the educated person' (Heron, 1974:4). Kilty, (1978) also assumes that self-assessment is self-referenced

although he suggests that the development of these skills are enhanced within a supportive peer environment. However, both writers were situated within a humanistic tradition and were not concerned with problematising the assumptions behind their conceptualization of self.

In his more recent work, Boud (1999) with reference to Smith and Hatton's (1993) work, in reviewing the development of reflective practice, alludes to the complex environment which impacts on the student's engagement with the concept of self-assessment. His analysis of three different interventions aimed at promoting reflective practice suggests that those required to write an essay with no dialogue with others were the least successful in engaging with the topic. In contrast, those prompted by an academic were constrained by the authority of the staff member, whilst those who were prompted by peers demonstrated the most reflection. This example provokes uncertainty about the validity of humanistic traditions in focusing on the individual as the key factor in determining self. This example would suggest that factors external to the individual have an influence in mediating the activity. Boud (1999) goes on to observe that this example only points to a local context. He draws our attention to the wider environment in which social forces, such as gender roles, racism and the protection of personal stakes all impact on the individual's experience. In this discussion, however, he does not provide a substantive analysis as to how these multiple layers affect individual experience. Neither does he offer an examination of the relevance of this observation to the development of self-assessment initiatives.

Drawing on Gilligan's (1982) observation about women's constructs of self it would seem plausible that women have a less contained sense of self. They may not conform to

the self-referenced concept and in contrast seek out other indicators to inform their development. This analysis brings into question the assumption that the construct of self is constrained within or with reference to the individual. In my own experience of working predominately with women students, it seems that they do use a range of experience and reference points. These include using their codes of conduct and peer feedback to inform their development and evaluation of self-assessment criteria. This observation has parallels with Mason's (2001) argument that the construction of self-identity is dependent on reflexive self-awareness. Since he also argues that contemporary society lends to a climate of reduced moral responsibility. I would suggest that this reflexive awareness needs nurturing in a climate of trust within the learning environment.

Mason's (2001) assertion that in modern society the reflexive construction of identity is less clear and more fluid than in traditional society led to a review of the perception of professionals. This includes contrasting the dominant view of the professional as the autonomous expert with that of someone who has to continually review and adjust their approach in a contemporary health care setting.

2.9 Nature of professional practice

The nature of professional practice is contested territory. As Carr (2000) asserts, traditional constructs assume that professionalism by its very nature demands a high level of integrity. He goes on to suggest that in the past professions, as distinct from vocations, have been seen to consist of types of regulated practice measured against fairly defined codes of conduct or principles of procedure. He argues that:

> The normative core of the concept of profession consists in a system of ethical principles expressible as *duties* or *obligations*
>
> (Carr, 2000:248)

Other attributes of the professional are perceived as, the possession of knowledge a complex and valued commodity that is achieved through a lengthy, formal and systematic training, control over education and the workplace, and self-regulation through a statutory body. It is also assumed that the professional has an orientation towards others, which is altruistic rather than expectant of financial rewards (Davies, 1995).

Carr (2000) suggests that the construct of professionalism in health care is associated with assumptions of need for health care as a fundamental human right. Indeed, he suggests that the normative description of professional conduct assume that professionals deliver services, unlike tradesmen, for example, which cater to a fundamental human need. However, contemporary contexts throw into question assumptions of basic human need. For example, technological advances now mean that perceptions of life expectancy and quality of life have dramatically changed over the last few decades (Symonds and Kelly, 1998, Davies et al., 2000) . People who suffer from heart disease or chronic renal failure now assume that organ transplant has become a routine procedure. Does this meet the criteria of meeting a basic human need?

The assumptions about integrity deriving from the sense of expert knowledge and altruistic service to others are incongruent in the contemporary health care context. Stacey (1992) argues that within an environment demanding collaboration between health care professionals and a shift in the communication with clients, the traditional view such

as that recounted by Carr (2000) is outmoded. In a similar vein, Walmsley et al., (1993) argue that professional knowledge is not something fixed and impersonal, derived from a established set of abstract principles, but depends on a range of factors informing the context. These include respecting diversity, working in an empowering manner with clients and working in teams. In addition, these authors argue that the relationship with the user could be more important than the professional's expert knowledge.

2.10 Professional practice in nursing

An even stronger challenge to the traditional perspective on professions has been mounted with respect to the nursing mission to achieve professional status by sociologists such as Davies (1995, 2000) and Porter (1992). This is largely because the nature of nursing as an occupation is substantively different from what Davies describes as the 'malestrom' of medicine with which it is often compared. For example, Davis (1995) draws to our attention the differences between the doctor's consultative relationship in contrast to the nurses sustained relationship with the client. Unlike the doctor, the nurse is likely to have an ongoing and sustained relationship with the client, which arguably affects the professional relationship with the client.

This difference in relationship affects the power dynamics between the nurse and the client. The literature also suggests that the wider context influences the nursing profession's response to agendas, such as empowerment and accountability. For example, Davis (1995) and Chavasse (1992) argue that since nursing is predominately a female occupation nurses are at a disadvantage in working to agendas of empowerment. This is

because they have traditionally been socialized into a culture which has been subordinate to medicine.

Davies (1995) argues that nursing work is substantively different from that of medicine and advocates re-framing the analysis to considering one in which a new professionalism is conceptualised, which will provide a backdrop for the critical evaluation of nursing work. This contrasts with Robertson's (1996) view with reference to teachers' work. She argues that the new professionalism is a construct emphasizing the erosion of professional responsibility rather than 'different' to previous perceptions of the concept.

With respect to the world of education, Hargreaves and Goodson (1996) suggest that these contrasting views of professionalism emerge from the emphasis on different aspects of professional experience. Professionalism can be seen as development arising from increasing complexity of the work environment, the need for collaboration between individuals and agencies and increasing emphasis on the range of competencies required for practice. In contrast, sceptics suggest that social complexity, government decentralisation resulting from financial control and state power combine to erode the professional project. The nursing field experiences similar agendas and the individual may state that they have a sense of both sides of the debate. That is to say that they may have opportunity to develop a range of skills and competencies, and work in very different ways than their counterparts from previous generations. They may also experience a disjunction with the systems of accountability that they are required to engage with.

2.11 Community Nursing: A case for complex professionalism

The debates affecting the wider nursing context extend to the Community Nursing context. However, nurses in the community context are directly confronted by the current debates emanating from a range of situations and stakeholders. For example, the current agendas in the development of Primary Care Groups and more recently Primary Care Trusts have challenged Community Nurses to engage in strategic planning. The White Paper, NHS Modern and Dependable (DOH, 1998), for example, inferred that Community Nurses would be required to engage in strategic planning including, building population profiles and contributing to local policy agendas.

Current public health agendas also illustrate a change in the conceptualization of responsibility within Community Nursing contexts (Kemshall, 2002). Some branches of Community Nursing, such as District Nursing have traditionally focused on individual client encounters (Gastrell and Edwards, 1996, Blackie, 1998, Symonds and Kelly, 1998). Whilst some emphasis continues to be placed on the nurse's interaction with the individual client, attention is now being drawn to the nurse's responsibility in supporting strategic developments on a population level. This throws up some fundamental dilemmas for Community Nurses. As Kemshall (2002) argues, there may be a conflict of interests in deciding how funding is allocated. Should Community Nursing services be directed into providing health care messages to the wider population or should the emphasis be on the health practitioner's responsibility to individual clients in providing direct care and health-promoting initiatives?

The context in which a Community Nurse makes ethical decisions is therefore complex and is informed by a range of factors including their responsibility to the client, the

organizational context and the wider society. Here the more obvious parallel is with Hargreaves and Goodson's (1996) notion of complex professionalism. They argue that this concept arises from an environment in which competing interests, such as those emerging from government policy, organizational goals, working relationships and personal skills and values impact on the professional/client relationship.

Community Nurses find themselves engaging with new agendas, such as managing and directing care requiring skills in delegation and supervision which their own education and training may not have prepared them for. Increasingly they are also required to interface more overtly with other health and welfare agencies. This brings with it other concerns about working with agencies that may not subscribe to the same value base. For example, changes in legislation require that District Nurses refer 'basic care' such as bed baths and hygiene care to social services since this is no longer constructed as nursing work (Malin et al., 1999). However, this role may not be perceived as a service provided by social services since they have a role in monitoring and evaluation of care but do not necessarily directly provide services. This then means that the client has to be encouraged to contract services from a private company. This does not sit well with many clients who have been brought up with the notion of the welfare state as free at the point of delivery (White, 2002).

This dynamic lends itself to Hargreaves and Goodsons (1996) development of a theory of postmodern professionalism in which they suggest that the following relationships emerge:

1. *Discretionary judgement* over issues which directly affect the client group,

2. Opportunities to engage *with moral and social purposes,*
3. Commitment to working in *collaborative cultures,*
4. *Occupational heteronomy* rather than self protective *autonomy.* This requires working openly with clients and other agencies in the wider community,
5. A commitment to *active care,*
6. A search for *continuous learning,*
7. A recognition of high task *complexity.*

(Adapted from Hargreaves and Goodson, 1996:21)

This analysis takes us away from the dichotomy of gender differences as described by Davies (1995) and into a realm which engages with contemporary working practices in health care.

2.12 Decision-making: limitations of rational models in inter-professional areas

According to Bryans and McIntosh (1996), theories of decision-making are found in abundance. However, these authors draw attention to the lack of literature on decision-making in Community Nursing contexts. They assert that although research is done on the decision-making of nurses in hospital settings, that of Community Nurses has been largely ignored. This is significant since in their view Community Nurses face 'different challenges than those encountered by their hospital colleagues' (1996:24).

Agendas such as inter-professional and partnership working, referred to above contribute to the nature of problem recognition and the dynamics of decision-making in Community Nursing contexts. Experience suggests that the Community Nurse is more likely to be directly confronted by a myriad of stakeholder interests as well as the immediate question relating to care assessment and delivery. The issue involves balancing these interests whilst maintaining a focus on the client's welfare.

Carol and Johnson (1990) suggest that there are seven stages to decision-making

1. Recognition,
2. Formulation,
3. Alternative generation,
4. Information search
5. Judgement or choice,
6. Action,
7. Feedback.

The recognition and formulation form a pre-decisional activity. Factors affecting these stages include, the nurse's state of prepardness and her personal view of her role as well as the situation itself.

Much literature related to decision making in nursing is predicated on the assumption that it follows a rational process, which does not take account the first of these two stages. Lister (1997) argues that since the outset the professionaisation project in nursing has adopted rational modes of academic practice which are associated with the scientific aspects of medical practice. The nursing process is evidence of this. It assumes that nursing decisions are guided by a rational process. However, the context would appear to be more complex.

The nursing process, which informs many texts on nursing, assumes a four stage model of care. These are assessment, planning, implementation and evaluation. Bryans and McIntosh (1996) argue that it starts by assuming assessment is a data gathering exercise which does not take into account the range of contexts in which nursing occurs. For

example, nursing in the home is varied because of the environment, lifestyles, family and neighbour-hood support systems, which inform the client's circumstances. These factors require the nurse to adapt to a range of circumstances in situ. In addition, he/she may also be involved in the care of a client over a protracted period of time and decision–making therefore has a temporal aspect to it.

Today many Community Nurses act as team leaders and are responsible for delegating care. This implies that they are involved not only in assessing care needs but also in monitoring and directing care through another. This suggests a model of leader mediation in decision-making (Northouse, 2001). Northouse suggests that this involves monitoring and action taking. The first decision therefore is to decide whether it is time to gather and interpret information or time to intervene and shape the course of team activity.

Community Nurses not only contribute to discipline specific teams since within Community Care settings are these are most likely to be inter-professional (Malin et al., 1999). The disciplines comprising these teams have, according to Wilmot (1995) very different value bases. Nursing is predicated on an individualist model and is client focused whilst social work subscribes to a collectivist approach. However, the decision-making frameworks described above do not address the influence of values and morals, which inform practice. Malin et al., (1999) argue that decision-making in inter-professional arenas is influenced by the power dynamics within the situation. Whcre minorities seek to influence the agenda, it is those who are able to express their views consistently who are able to affect the agenda. This would suggest that Community Nurses need to address the values that underpin their perspectives on care in order to

critically review them and articulate them to others in order to influence the decision-making process.

2.13 Ethics and professional practice

The literature on ethics related to nursing practice reflects the tension between the personal and the political which threads through other aspects of this review. Drawing on theorists such as Benner (1984), some authors examining the nature of ethics in nursing continue to place the emphasis on the nature of the direct encounter with the client. Those aligned with evidence based practice in contrast advocate objectivity, cost effectiveness and standardised patient care but without problematising these concepts (Thompson et al., 2000). These perspectives derive from competing agendas and mirror tensions evidenced in other aspects of this review. The ethical concepts which health care education continues to engage with emphasize bio-medical ethics and unusual events giving scant attention to the wider ethical concerns impacting on health care agendas. This results in disparity between the wider debates informing nursing practice and those discussed in relation to ethical case focused dilemmas. For example, Community Nurses are engaging with debates affecting the client population including efficacy of care regimes as well as managing direct care (DOH, 1998, White, 2002). This realignment of nursing roles requires a re-assessment of the ethical perspectives nurses need to engage with resulting from concerns such as:

- The sustained relationship with the client,
- The re-conceptualisation of the patient as involved in their care moving away from a dependency orientation,

- A tension as to the efficacy of treatments which have come about as the result of technological advances such as transplants and assisted living,
- A perception of people as being able to influence their own health status,
- A move towards public health agendas in which health-care is addressed on a population basis.

These factors contribute to different perspectives in reviewing ethical principles. For example, we might see the emergence of literature not only focused on decisions about individual client care reviewing on the principles of duties and obligations, but also addressing a broader agenda about the orientation and purpose of care.

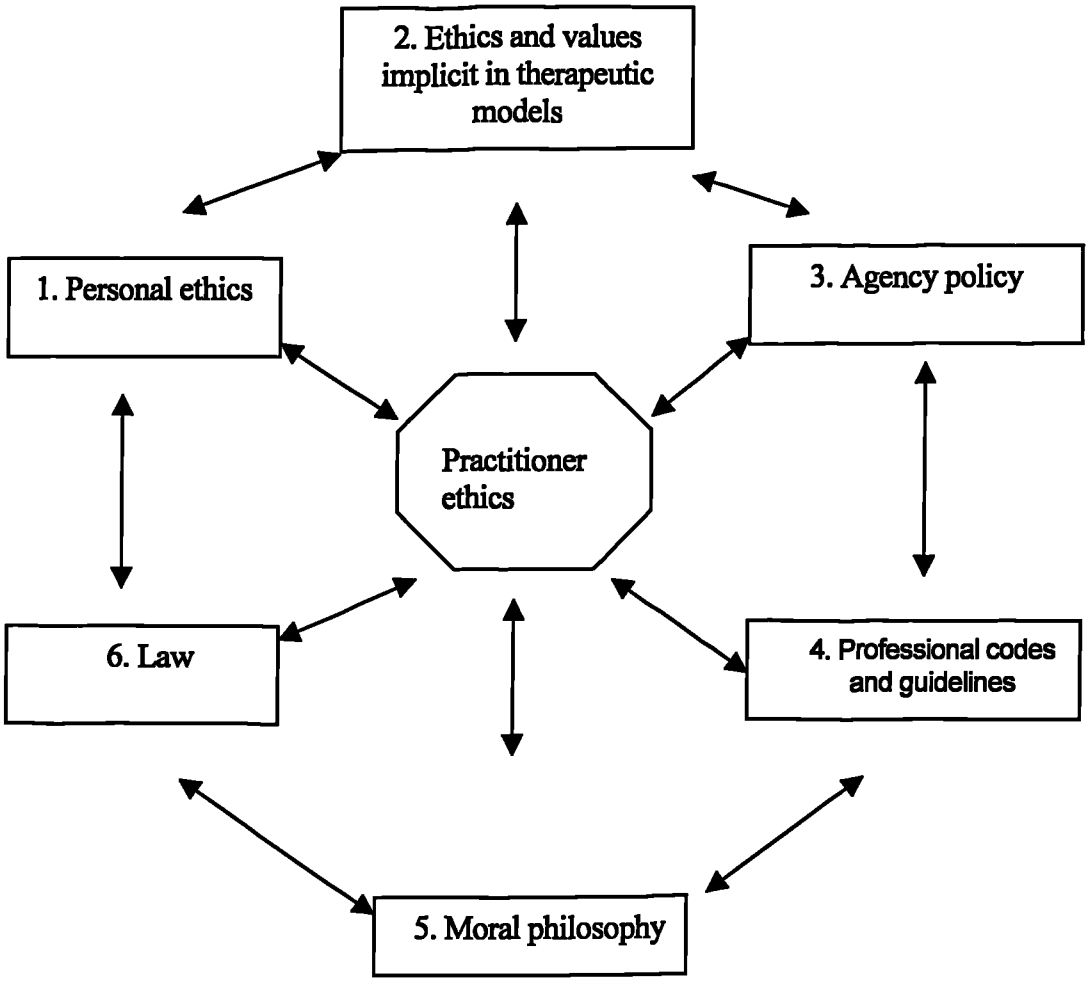
Changes in the power dynamics both in direct encounter with clients and in the wider orientation of nursing practice must result in a re-framing of the ethical perspective. These changes are occurring within the organizational, political and ideological climates influencing nursing practice and must inform Community Nurses' knowledge and interpretation of ethical dilemmas. This leads us to question how practitioners develop and interrogate these frameworks. It also begs the question as to how education can enable nurses to engage with ethical principles and enhance this area of professional development.

As the discussion above illustrates, constructs of self and by implication ethical perspectives are shifting within today's complex society. Campbell and Marshall (1999) argue that within society at large the concepts of ethics and morals have become recurrent issues for debate throughout the social sphere in recent years. The examples given above

indicate that there are a range of complementary concerns, which pervade the discussion centering on the relationship between the state, society and the individual. For example, questions are posed about the nature of individual responsibility to others and the form that this should take and recent political debates raise issues about the role the state should take in supporting collective and/or individual welfare. Questions abound about the nature of values, beliefs and duties informing agendas affecting the public interest. Community Nurses similarly contend with the legacy of the new right policies of the 1980s and the 1990s and the changes in emphasis in responsibility and roles of professional practitioners in health and welfare sectors (Blackie, 1998, Kemshall, 2002).

Within the field of counselling, which arguably mirrors the caring elements of nursing practice, Bond (2000) argues that practitioner ethics are informed from a range of sources as outlined in figure 3.

Figure 3: Sources of professional ethics



(Adapted from Bond, 2000:39)

Drawing on Bond's (2000) framework one can see that the context in which nurses operationalise ethical frameworks is complex. However, even this matrix fails to address the impact of the business culture that has developed over the last decade. The notion of cost effectiveness has dramatically affected health care delivery over the last ten years and the agendas for efficiency, accountability and individual responsibility has directly affected health care workers. For example, Community Nurses have had to address issues of resource management in assessing and managing care (Dracopoulou, 1998a, Kemshall, 2002). Malin et

al., (1999) argue that Community Nurses have traditionally had an individualist perspective on care based on the values of care and obligation. This contrasts with that of other professionals such as the social workers emphasis on collectivism and rights based. Neither perspective however, addresses the emphasis on resource allocation that has become more evident since the advent of the market economy in welfare since the 1980s. This emphasis is reflected in Grimshaw's (2001) typology of business ethics in which economic efficiency, equivalence, contributive and environmental concerns also form part of the ethical value system.

Figure 4 Business code of ethics

Ethical constructs	*Key descriptors*
Integrity	Duty, responsibility, honesty, trust
Equality	Equal treatment for all
Economic efficiency	Producing right goods/services at lowest cost to satisfy consumer needs
Equivalence	Promoting equality of buyers and sellers in the operation of markets
Distributive	Distribution of the benefits and burdens of group activities among group members in equal fashion by superior authority
Contributive	Duty to support the group from which he/she benefits
Environmental	Takes note of social issues such as pollution, health and safety, participation, community impact and affirmative action

Grimshaw (2001) Derived from Tucker et al., (1999)

Integrity again emerges as a central concept as it did in the debates on professionalism. Here it is imbued with notions of honesty and trust and is assumed to be a property of the individual. This is problematic within the context of changing practices and inter-professional agendas.

Tronto (1993, 1995) with reference to the development of an ethic of care, draws our attention to the context in which ethics are adopted. She argues that we need to consider

their relevance to the contemporary society and the space that they hold within the political sphere. She goes on to suggest that the way in which we think about moral life affects the kind of moral arguments we find persuasivc. For example, in 1948 when the National Health Service (NHS) was first established, there was an overriding assumption that health care would be universally available (Williams, 2000). However, as we have seen the cost of health care escalate with technological advances, and longer life expectancy becoming the norm, there have been some moves to limit the services available on the NHS. As a result, we saw the introduction of the purchases provider culture and the limitation of some services, concepts which would have been alien in the post war era (White, 2002).

This leads to some important questions, for example:

- How do practitioners articulate their ethical perspectives and make decisions about their ethical stance?

- Does their role as representatives of welfare agencies such as the health service affect their ethical stance and inform the dynamics of their ethics in practice?

- How does their professional education and training prepare them to grapple with the complex world of practice in which they contend with a myriad of personal, client, professional, welfare agency and political agcndas?

2.14 Summary of emerging themes

This discussion demonstrates that there are a range of factors influencing constructs of self, assessment, self-assessment and professionalism and ethical frameworks. These

include the increasing complexity of social life, challenges to established value systems and changing expectations of the individual both within the personal and public sphere. A key concept, which seems to either overtly or tacitly inform the discussion both within the literature and in the focus group discussion is the challenge to the concept of integrity. Within the deliberations on constructs of self and identity, it emerges as contributing to the integral whole of the person. Within the discourse on professionalism it is associated with a sense of the autonomous expert who works in an altruistic manner with clients. However, in contemporary society, Mason (2001) contends that the individual emerges from a myriad of fractured experiences. He argues that at a time when political individualism and technical rationality prevail, we are seeing the reduction of a sense of moral responsibility with which integrity is associated. He suggests that with the collapse of 'pre ordered things' (2001:47) there arises opportunity for individuals to exploit their relationships and demonstrate minimal concern for others.

Within nursing there remains an assumption that nurses have a connectedness with and a level of responsibility for others. Davies (1995) argues that this sense is associated with the gendered nature of nursing practice. However, she asserts that the masculine construct of professionalism is pervasive. She contests the assumption that nursing should aspire to similar ideals and advocates a re-conceptualization of professionalism to take account of the sustained relationship that nurses have with clients. The dynamics of identity and the constructions of boundaries between self and others arise in her view from structural forces, her emphasis being on gender. Williams (2000) also argues that within this construct, power is the critical determinant influencing action, agency and structural factors which constrain the individual.

Whilst medicine continues to have a dominant position with respect to nursing there have been some apparent shifts in practice in health care settings over the last few years. Health care professionals are currently being required to work in different ways, such as engaging in inter-professional working and empowering clients. Whilst there continues to be an underlying assumption that the professional will strive to work towards the client's best interests, the sense of responsibility has shifted from the autonomy of the professional to one which respects the client's perspective. With shifts in policy to agendas, such as partnership, collaboration and inter-professional working, integrity may be seen as a team attribute as well as that of the individual. This conceptualization has similarities with Hargreaves and Goodson's (1996) concept of heteronomy and the need to develop open and collaborative ways of working. However, given Mason's (2001) view of the destruction of the individual as a coherent whole and the resultant fracturing of the self there is potential to disrupt a coherent sense of moral responsibility for individual members of the team. Similarly, the agenda for empowerment has the potential to erode the sense of integrity as an attribute invested in a professional's expertise since the relationship the professional develops with the client is as important as their specialist knowledge. The challenge then is to capture the concepts of integrity and ethics as dynamic and relational. This might also involve considering the positive aspects of the new professionalism, such as sharing responsibility rather than to see it as exclusively contributing to erosion of established practices.

The themes presented here emerged from a cyclical process both from the initial literature review and from the discussions with focus group members during the fieldwork. This has led to a further interrogation of the data in order to uncover the

experience of individuals engaging in these agendas and the significance this has for their understanding and application of ethical principles. These issues are therefore explored further in thc data analysis section of the study. Chapter three will now describe the methodology and methods employed in the research.

3 Chapter 3: Methodology and Methods

3.1 Introduction

This chapter will offer an overview of the researcher's journey in determining the topic of study, the methodology and methods employed to conduct the study. It will discuss the nature of research and the current debates affecting research design in order to offer justification for developing a collaborative approach within a postmodernist framework. It will then, bearing in mind the caveat outlined in chapter two with respect to the use of a modernist framework, draw on Lincoln and Guba's (1984, 1994, 2000) protocol, as a framework from which to explore the research process. The next section reviews the development and implementation of the focus group discussions. This will include an exploration of how a commitment to a postmodernist and collaborative approach affected the development of the research instruments.

3.2 Preliminary concerns informing the development of the project

This study emerged from my interest in self-assessment and paralleled my personal journey firstly as a health visitor and latterly as an educator of Community Nurses. During this process, I have become increasingly aware of the complexity of decision-making in Community Nursing practice and have become inquisitive about what informs practitioners' approaches and choices in decision-making. In particular I wish to explore how ethical principles inform the process. As Strauss and Corbin (1998) argue such a concern is a legitimate starting point in initiating a research project. However, as I deliberated the focus of the study it became apparent that the concepts and links I was hoping to explore are complex. In addition, as the literature review revealed, there was

little in the literature about the key concepts relating to the Community Nursing context. Miles and Huberman (1994) argue that in such a situation, one has to establish 'just what the something is' (1994:91) in order to explain the relationship between concepts being explored in the research process. Thus the concepts of self-assessment, ethical frameworks in Community Nursing contexts and decision-making had to be opertionalised in order to inform the development of the project.

The research questions were exploratory in nature and the project was therefore likely to fall within the qualitative paradigm. Devine and Heath (1999) assert that the research process derives from a range of complex choices of method(s) in developing a research strategy. The major challenge for the researcher is to choose a combination of methods, which fit the topic of enquiry. However, Schutt (1999:396) asserts that the 'potential for integrating methods and combining findings does not decrease the importance of single studies using just one method of data collection'. Indeed, he goes on to state that 'well-designed studies in carefully researched settings provide the foundation for broader integrative studies'.

Within this project, I moved from a position of assuming that triangulation, which seeks to capitalize on the strength of a combined approach and compensate for the weakness of each (Punch, 1998), would demonstrate good practice to one of engaging with a purely qualitative approach. However, one of the issues that impinge on my experience of conducting social research is my position in a context in which 'scientific' and more specifically 'quantitative' research inquiry is privileged. This as Neal (1998) suggests, is the dominant position within HE environments. Troyna (1994) also argues that within the realms of educational research, little attention is paid to alternative approaches, such as

feminist and anti-racist methodologies. He contends however, that educational research should broaden its horizons to encompass cross-disciplinary approaches. The implication is that research, which engages with methodologics which do not match the dominant paradigm within the field of study have difficulty in being accepted as relevant and meaningful. Alvesson and Scoldberg (2000:177) allude to similar tensions in their analysis of why novice researchers move towards a postmodernist approach. They suggest that the postmodernist position in effect 'defines away all established authorities' so that researchers can carve out a new space.

Goodson (1995) cautions us to be careful, however, in emphasizing 'personal knowledge in the form of narratives and story' (1995:56) since these genres may occlude our sense of the wider perspective. He argues that economic restructuring results in cultural redefinition and in consequence modes of political and cultural analysis are being re-defined. One of the difficulties of this restructuring of the theoretical genre is that an emphasis on the personal and local negates aspects of 'general patterns, social contexts and critical theories' (Goodson, 1995:57).

This tension between critical theory, theorizing gender as a macro phenomenon and the postmodernist focussing on the personal experience is evident within the literature review. I have found difficulty in reconciling theories, such as Davies' (1995) analysis of gender relations with Young's (1995) sense of serial identity, and Mason's (2001) view of fractured selves. It is hoped to reconcile this tension by drawing on Layder's (1994) research map to raise my awareness of the ways in which the respondents discourse reflects different levels of social interaction. My aim being to find a way of conducting

research which would allow for the exploration and interrogation of the multiple layers of social activity including personal experience and context.

The concerns expressed above reflect Punch's (1998) assertion that in contrast with quantitative approaches to research, qualitative research is dominated by the sense of diversity. Research methods employed in this paradigm are a 'complex, changing and contested field' (1998:139). As Denzin and Lincoln (1994) state:

> the field of qualitative research is far from a unified set of principles promulgated by networked groups of scholars. In fact, we have discovered that the field of qualitative research is defined primarily by a series of essential tensions, contradictions and hesitations. These tensions work back and forth among competing definitions and conceptions of the field.
>
> (Denzin and Lincoln, 1994:ix)

Within qualitative research there are a range of positions which the researcher can take. One of the key effects of such developments is to recognize the political nature of social research.

3.3 The contribution of reflection to the research design

As this research project began to unfold, I realised that my initial research problem needed to be re-conceptualized. As I discussed my project informally with colleagues and began to review the literature, it became apparent that I needed to establish some basic tenets in relation to the concepts being studied. There were too many variables making it difficult to establish a causal link between exposure to the concept of educational self-assessment and ethical frameworks employed by Community Nurses in practice. My starting point had to be more exploratory in nature in order to get some sense of what

these terms meant to the practitioners. I was also aware that the assumption that a causal link that assumes that truth can be established was inappropriate to my approach to the research.

This process made me more aware of the nature of the questions, and I started to review my own position in relation to the project. This included reflecting on my own professional trajectory and questioning my assumptions and beliefs about the nature of professional practice and the context of decision-making. It also made me reassert my sense of research as a politicized endeavour. This experience confirmed my initial thoughts that I wanted to develop a reflexive methodology, which would enable me to examine the research process in parallel with the topics of study.

Alvesson and Skoldberg (2000) suggest that reflection centers on thinking about the conditions which influence what one is doing. That is examining the theoretical, cultural and political contexts which impact on individual and intellectual involvement on the research topic and uncovering aspects of these which are difficult to become conscious of (2000:255). In reflection, one is attempting to uncover our modes of thinking, our ways of seeing, and use of language. Steier (1992) argues that the core of reflection is in the interest in the way we construct ourselves socially while also constructing the subject of the research. The research endeavour becomes one of constructing the area of investigation whilst simultaneously constructing the self as researcher within the social and political context. The key however is in not allowing one or other aspect of this process to dominate. Given the topic of study here, which was provoked by my experience of self-assessment both as a student and as an educator, the project could become what Alvesson and Scoldberg (2000:255) describe as a 'house of mirrors'.

Meaning that the researcher could become absorbed with self-reflection without reference to the wider political context.

The research design therefore acknowledges the author's journey, whilst placing an emphasis on uncovering the respondents' perspectives. It seeks to contextualise these with reference to the wider political environment. The purpose is to prompt the theory generation to uncover different ways of seeing and constructing the topic of study. The process includes self-reflection on the part of the researcher; a process of reflective dialogue (Brockbank and McGill, 1998) with the research population and a deconstruction of the text(s) in an attempt to uncover alternative or new perspectives. The intention is to illuminate the experience of self-assessment and its relationship to Community Nurses' understanding and application of ethical frameworks.

3.4 The qualitative approach: Rationale for structure

Rudestam and Newton (2001) argue that it is often assumed that qualitative research is unstructured offering license to omit clarity and specificity in outlining the methods to be employed. They further assert that it is imperative to address the planning process in conducting research and that issues of soliciting respondents, selecting and preparing research materials and formulating research instruments are important considerations when conducting research. They refer to Lincoln and Guba's (1984) protocol for designing research projects in order to offer a systematic approach to qualitative research, which include:

1. Determining the focus of the inquiry,
2. Determining fit of paradigm to focus,

3. Determining the fit of the inquiry paradigm to the substantive theory selected to guide the inquiry,
4. Determining successive phases of the inquiry,
5. Determining instrumentation,
6. Planning data collection and recording modes,
7. Planning data analysis procedure,
8. Planning the logistics,
9. Planning for trustworthiness.

The protocol items are not necessarily undertaken in a linear sequence, nor are they necessarily exclusive. For example, there is a significant degree of overlap between planning the logistics, data collection and recording modes. An important consideration, given the postmodernist approach adopted here, is that the first three items suggest that the researcher pays specific attention to the assumptions that underlie the study as well as the fit between the methodology being used and the research question. Within the postmodern paradigm, additional concerns include seeking a sense of multiple voices and authenticity from the data. The process of interpreting and reporting the data therefore includes seeking a more overt contribution from the respondents in confirming the emerging themes.

The subject of this study, in which one aspect is focused on the impact of self-assessment as a developmental tool, suggested that a model of research with engages respondents in the design and development of the project was the approach of choice. Discussions on self-assessment often center on the nature of anti-oppressive practice and the ways in which students can be empowered within the world of practice (Hinnet and Thomas, 1999). Since the nature of self-assessment is a significant aspect of the study, it seemed

appropriate to attempt to capture the underlying spirit of this philosophy within the research methodology.

A postmodernist analytical framework, which according to Fox (2000) lends itself to collaboration between researcher and respondent therefore, informs the research design. He argues that one of the underlying principles of the postmodernist paradigm is in valuing the contribution of all in the development and acknowledgement of the research endeavour. This relationship he considers to be a fundamental precept of the ethical framework in which the research takes place. The respondents were, therefore invited to contribute to the research design and affirmation of the accuracy of recording and interpretation of the data.

This research draws on Doherty and Elliott's (1999) argument, which suggests that it is insufficient to cast the subjects of research as merely a user group. This infers that the respondents should be actively involved in the gathering of the evidence and in interpreting the data. In extending this argument, the respondents in this study were invited to contribute to the research design and the dissemination process, which emerged from it.

The choice of a postmodernist methodology therefore seemed to be one that would allow the power dynamics of the research topic and the research process to be explored. However, as Alvesson and Skoldberg (2000) assert, within the postmodern paradigm one of the difficulties is in the overriding concern with the rhetorical or communicative aspects of theoretical discussion. Such concerns can pervade to the exclusion of aspects

of study such as empirical research. This issue had to be taken into account when designing the project.

3.5 The theory- empirical relationship: Authentic representation of data reflecting multiple voices

This study seeks to address the complex nature of decision-making within Community Nursing whilst simultaneously interrogating how practitioners develop the skills to critically engage with ethical decision-making. The relationship between the two necessitates engaging with the discourse in the theory and practice domains of Community Nursing practice and HE. The research agenda also results in engagement with the discourse within the field of research itself.

This resulted in reviewing the range of roles that have influenced my perspectives on the current project. These include those as an academic, as a former practitioner in the field of study and in my prior experience of research. The discourse informing different arenas according to Grumet (1987), controls our environments. It must be acknowledged therefore that these discourses influence both my own and the respondents' expectations, perceptions and interpretations of the research situation. However, as Flax (1993) and Foucault (1979) argue, there is an inherent inability to construct meaning outside of discourse. Ropers-Huilman (1999) argues that as critical researchers in a postmodern age we are:

> crafting meaning within discourses, telling the truths from our vantage points and struggling to paint a picture of the discourses in which we are operating.... it involves a sense of past and future, of situatedness within the fabric of time and space
>
> (Ropers-Huilman, 1999:23)

She goes on to argue that it also involves a 'careful listening to others' accounts.

As Alvesson and Skoldberg (2000) observe, a postmodernist stance may result in a shift away from theorising data and interpretation towards language and presentation as central aspects of the research. The intention is to try to represent the reality as the population experience it and accept diverse interpretations of reality.

Alvesson and Skoldberg (2000:69) argue that representation and presentation 'emerge as crucial methodological problems'. They contest the traditional view that the reporting of data, analysis results and interpretation and theory generation are unproblematic productions of text. They assert that the research process is itself politicized and that a neutral social reality that can be depicted or interpreted does not exist. As the author of this dissertation, I am critically aware of my impact on the research process. For example, I was acutely aware that at the outset by posing my original question would have a major influence on the study. The question, whilst it does reflect contemporary concerns within the field informing the study, also arises from my personal trajectory in relation to concerns about professional and academic practice. This realization has made me very conscious of the need to listen attentively to the concerns and issues raised by the research population. This was important on two levels:

1. In achieving my goal in developing a partnership approach to the research.
2. In attempting to represent an authentic account of the data.

Within a critical postmodernist framework, research intends to be transformative. As Tierney (1994) argues:

> Research is meant to be transformative; we do not merely analyse or study an object to gain greater understanding, but instead struggle to investigate how individuals and groups might be better able to change their situations.
>
> (Tierney, 1994:98-99)

Tierney (2000) asserts that however flawed the research endeavour is we should not lose sight of its potential to affect change. He disagrees with the postmodern view that change is impossible and challenges it to address oppressive practice by giving voice to those who are marginalised and disadvantaged. In doing so we are not moving towards an overarching assumption that there is a right way to engage with change but rather becoming aware of diversity and different perceptions of reality. In producing the text one must therefore be aware of the reality and perspective being presented and the power dynamics inherent in the way we represent the research process.

3.6 Qualitative research: The collaborative approach in practice

The power dynamics informing research agendas have profound affects on the way in which research is conducted, analysed and reported on. Stakeholders include funding bodies, parties with interests in the subject of study as well as those with control over access to the research population; those offering resources as well as those in the direct encounter of researcher – respondent(s). Within this research endeavour, I as the researcher following Doherty and Elliott's (1999) example, wished to promote an environment of collaborative enquiry, which would raise the profile of the respondents to one of active engagement with the research process rather than one of passive subject.

Players in this research activity all share experiences of engaging in self-assessment and have professional trajectories in Community Nursing. Since the purpose of this research is to explore the nature of self-assessment and its relationship with ethical principles evidenced within professional practice, it is important to recognize and acknowledge the expertise of all parties contributing to the project. However, as Schulz et al. (1997) argue, even a collaborative approach to research may be fraught with competing purposes and needs of the researcher and the respondents.

This study reflects Schulz et al's (1997) description of the agendas in narrative inquiry. The research design intended to enable the participants to engage in exploring personal accounts of their experience of self-assessment and its impact on their professional lives. Such inquiry is dedicated to exploring how people make sense of their problems in their lives and their work (Clandinin et al., 1993). This concern extends to the opportunity for respondents to authenticate the meaning ascribed to dialogue by researchers (Flax, 1993).

Connelly and Clandinin (1990) stress the importance of the mutual construction of the research relationship in which practitioners and researchers feel cared for and have a voice with which to tell their stories. Within this project, the focus groups were intended to enable the respondents to develop a culture in which they could share experience and engage in what Brockbank and McGill (1998) describe as reflective dialogue. The project went beyond asking for participation in the focus groups to asking respondents to engage with the interpretative and reconstructing phase of the study. However, as Schulz et al. (1997) suggest, it must be recognized that the respondents in the study will have less time available and this will therefore affect the power dynamics of the project.

Essential therefore to developing the project as a collaborative endeavour is the need to develop a climate of honesty and trust. Although the research endeavour intended engaging the respondents in all aspects of the design and development of the project, it had to be recognized that the respondents are all busy practitioners. The nature of the project necessitated asking the respondents to take part in their non-work time, for reasons outlined below, so that their professional integrity was not compromised. This could have affected the commitment to the project since it takes time to establish the environment of trust and sharing required in collaborative research. However, as Hollingsworth (1992) and Miller (1990) argue, this level of trust will greatly influence the quality of information shared in this type of research inquiry.

3.7 Focus group design and management

Focus groups as a method of data collection emerged in the 1930s in response to concerns that in traditional questionnaire surveys the spontaneous exchange and development of ideas that characterize social life were being lost. This was seen to compromise the validity of this type of research (Kruegar, 1994).

Focus groups have a number of strengths. They offer an opportunity to bring together a number of individual perspectives in a short space of time. Participants can interact, reflect and respond to other's perspectives. Some of these perspectives may be new to members of the group which may increase the dialogue and ideas generated from the discussion. According to Harvey-Jordan and Long (2002), this results in data being generated quickly and relatively cheaply.

3.8 Rationale for the focus groups

Focus groups according to Krueger (1994) should be considered when;

> Insights are needed in exploratory or preliminary studies ....
>
> *and*
>
> There is a communication gap or understanding gap between groups or categories of people.
>
> (Kruegar, 1994:44)

In this study, the first of these criteria was met since there were two key areas which the respondents' views might inform:

1. The impact of self-assessment on long-term learning and practice, and
2. The ethical principles Community Nurses operationalise in decision-making.

Regarding the first, although the literature review suggests that self-assessment contributes to critical thinking (Boud and Felletti, 1991, Boud, 1995, ENB, 1996b, Cowan, 1998, Boud, 1999, Cowan and George, 1999), it revealed nothing about the long term effects of exposure to self-assessment following the completion of educational programmes. Whilst it is demonstrated that self-assessment may have an impact on the engagement of students with learning and assessment processes on educational programmes there is no reported evidence that any change is sustained or developed.

In addition, practice suggests that there are differences in understanding of the concept of self-assessment between people, such as students and academics. For example, there was evidence of a mismatch between assumptions made by academics and students as to the purpose and impact of self-assessment on the educational process. In tutorials, students were suggesting that self-assessment had enabled them to develop their critical thinking

skills and learning processes. This is a phenomena reported elsewhere, for example, in the Self Assessment in Professional and Higher Education Project (Fitzpatrick, 2001), whilst some academics were perceiving it to be merely an addendum to a range of assessment methods.

With respect to ethical principles, there was scant literature about how Community Nurses engage with the ethical decisions they make in their everyday working practice. As Seedhouse (1998, 2000) has argued, the literature relating to ethics in health care settings focuses on bio-medical ethics and particular types of events or incidents which he terms 'hot spots'. In addition, there is little literature about practitioners' perspectives or discussion about how the process of ethical deliberation actually happens in everyday practice.

The focus group therefore provided an opportunity to enable former students to contribute their views to the discussion. It was felt that a focus group discussion would enable the ideas to be generated and developed by group members who are:

- Known to have engaged in self-assessment, and
- Currently engage in ethical decision-making in Community Nursing practice.

3.9 Focus group participants: characteristics, numbers and recruitment

According to Schutt (1999), focus groups consist of unrelated individuals who come together at the invitation of the researcher. Focus groups do not involve representative samples but participants do share key characteristics of the target population. As Krueger (1994) notes, the focus group should consist of an homogenous group of people but with sufficient variation to allow for contrasting opinions. The defining characteristics of the

group were to be that they had undertaken the self-assessment process in the WWP module and are currently practitioners in the field of Community Nursing. This would allow for expression of a shared experience in self-assessment and diversity resulting from clinical training and experience.

Krueger (1994) suggests that the ideal size of a group of this nature is between six and nine participants. This allows members of the group to feel comfortable in offering their perspective whilst allowing for enough potential variation of opinion to provoke discussion. The aim was therefore to recruit up to nine participants to attend the focus group discussions.

3.10 Recruitment and briefing

A purposeful sample, of six to nine former students, was recruited from the previous two cohorts of students who attended the WWP module of the CHCN course. This module includes a component of self-assessment, which forms the basis of the academic assessment protocol. It also informed the students' judgement of their competencies in their chosen area of communication skills. These practitioners are in full or part-time clinical practice and are involved in making complex clinical decisions. The research was seeking to explore if and how self-assessment informs clinical decision-making. Vaughn et al., (1996) suggest that purposive sampling is a procedure by which researchers select the research population based on predetermined criteria which would suggest that the subjects could contribute to the research topic. These criteria were that the students had experience of self-assessment and were currently nurses practicing within Community Nursing settings.

In order to achieve the target of six to nine respondents, I approached thirteen potential respondents. Vaughn et al., (1996) recommend that for every recruit another should be held in reserve. The recruits represented the range of disciplines in the CHCN course. The initial contact was by telephone or by letter. Some of the former students were already aware that a research project may be taking place and had expressed an interest in the project. Krueger (1994) recommends that the researcher makes personal contact in person or by telephone with the potential recruits. This was not possible with all the research population since a number of people were on annual leave when the first contact was attempted. However, the respondents knew me as the researcher since I had previously taught them and soon replied to my initial invitation.

3.11 Briefing information and consent

The recruits to this research project were members of the former student group. They were invited to participate in the study and to inform this process they were sent an information and consent forms. The information form outlined the following:

- The purpose of the research,
- The rationale behind the postmodernist approach and the implications for the development of the project as a collaborative endeavour,
- Options for participating and 'opting out' of the research,
- Methods of data recording, transcribing and confirming the accuracy of interpretation,
- That the tape-recorded material and transcripts would be destroyed on completion of this study and will not be used for further research.

The form also indicated that there would be further opportunity to seek clarification during the research process (see appendix 2).

The participants were requested to sign a statement that they were giving formal consent to participating in the research. They were advised that if at any point they wished to withdraw they would be able to do so without incurring any costs to themselves (see appendix 2)

The participants were advised that the research design would be determined in consultation with them but that in principle they may expect to attend three one-and a half-hour sessions at three monthly intervals. These were to be scheduled between May and November 2001.

The respondents were sent a questionnaire prior to the first focus group meeting to elicit some background information. Their past academic work was not used for the purposes of the research. The members of the focus group were told that the discussions were to be audio-recorded and field-notes would be taken. The transcripts of the audio recording were to be used with the members of the focus group to confirm the accuracy of the recording and interpretation of the discussions in keeping with the collaborative research approach. They were advised that it would be analysed using discourse analysis in order to examine the complexities of the discussions. This involves considering the discourse within context, looking for different discourses and considering if there is a hierarchy of discourse which may reflect power differentials in the situation. In addition, transcriptions were to be analysed using a computer-assisted package, such as NUD*IST for evidence of the emergent themes and links between them.

3.12 The biography of the respondents

The respondents had graduated with the CHCN degree within the previous two years. They had all taken the WWP module that required them to engage in self-assessment. They represented a cross section of the disciplines represented from the two cohorts including District Nursing (DN), Community Psychiatric Nursing (CPN), Community Children's Nursing (CCN) and Practice Nursing (PN). One person who had trained as a Health Visitor but now works in specialist liaison post was also interviewed since she was unable to attend the focus groups and it was felt her contribution would be useful. Interestingly, although the cohorts of students are described as a homogenous group, their different specialities have resulted in very different education and socialization trajectories. PNs for example, may have been in practice for a number of years prior to undertaking the course often within a very defined area associated with General Practice. CPNs in contrast may have experience in both acute and chronic psychiatric nursing both in hospital and community settings. DNs will have worked in acute adult nursing settings ranging from Intensive Care to care of the elderly prior to becoming Community Nurses (Edwards, 1996).

For some, the qualification is a requirement for practice, for example, for a team leader in District Nursing. However, members of the other disciplines may have been working in a Community Nursing role for some time and undertake the course to extend and develop his/her knowledge and understanding of his/her role. The entry requirement to the course demands that they are all first level registered nurses. One nurse held dual qualification of Registered General Nurse (RGN) and Registered Mental Nurse (RMN). The first level registration programmes, although they all require an agreed level of competency, reflect

a range of cultures and education philosophies. For example, the RGN in adult nursing will often have placed an emphasis on nursing sick adults within a hospital setting. Many theorists argue that in this context the emphasis is placed on the physiological and physical aspects of illness rather than on psychological aspects of care (Blackie, 1998). In contrast, Mental Health Nurse education emphasizes psychological and communication aspects of care (Davies, 1995).

The culture within Children's Nursing lends itself to working with children and their families. However, recent developments in this field have also emphasized the need to develop family centered care. The Community Children's services, within the context of supporting children with complex care needs have been dramatically extended within the last decade. This has resulted in children being cared for with technological requirements, such as assisted respiratory care and intravenous therapy at home. This requires the CCN to develop mechanisms to ensure that these procedures are carried out safely in the home, usually by members of the family. This development requires a shift of emphasis for the nurse in developing, assessment, delegation and educational programmes rather than always engaging direct care giving (Jones, 1996).

Practice Nurses are usually recruited from Registered General Nursing. The practitioners often have a history of working in adult nursing in fields, such as in accident and emergency. They may have been working as PN's for a number of years prior to taking the degree course. Practice Nursing was until the 1980s, a Cinderella service of Community Nursing. However, since the developments in the public health agenda and the targets arising from this in GP practice there has been an expansion and development

in the range of PN roles. For example, they now undertake specialist roles in diabetes management, family planning and asthma management (Smail, 1996).

Experience suggests that each of these disciplines and subsequent working context have a significant impact on the individuals' socialisation and practice of Community Nursing.

The respondents are employed at Grade G or above which implies that they have a significant role in managing and directing client care and in contributing to strategic planning. Five of the members of the focus group were working in practice whilst the sixth had been on maternity leave and returned to practice between the first and second focus group. The nature of their role is determined by a range of factors including the expectations of their discipline, the organisational context of their employment and the ways in which clients are recruited to their service.

All of the respondents were female. This is because only a few men undertake the programme and are mainly on the CPN pathway. This factor is perhaps significant given the discourse associated with the professionalisation project discussed in chapter two.

The age range of the respondents was from late twenties to mid forties. This distribution reflects that of the larger group. The contribution this might make to the respondents personal histories is not explored in-depth in this study although on some occasions the respondents alluded to the differences in their pre-registration training which may have affected their outlook.

3.13 Ethical considerations of location, time and data protection

In order to meet the ethical considerations inferred within a collaborative approach, the respondents were asked for their consent and were advised that they can 'opt out' at any point of the research. These points were reiterated during the focus groups.

Since the purpose of the study is to ascertain whether former exposure to self-assessment on a course undertaken at the University of the West of England affects their clinical practice, the respondents were asked to participate in the study in employer non-contractual time. In addition, the study was conducted on university premises and not on the respondents' employers' premises. This was because respondents may have wished to make comment about their practice or educational development which may have been negatively affected by employment structures and practices. As Babbie (1992) observes, the research process should never negatively affect the respondent and this caveat takes this into account. The decision to hold the groups at the university campus meant that they were held in the most central location. It also meant that the room would be available and that we would have access to relevant amenities which turned out to be an important consideration since I was able to offer the respondents sustenance on their arrival from a busy shift.

The focus group members were advised that during discussion they should identify each other by first names only in order to minimize the risk of identification if the tapes fell into the hands of others. In addition I gave the respondents alphabetical identifiers in the transcribed reports.

In order to meet the criteria laid down by the Data Protection Act (1998), details of the respondents were coded and kept separate to the data files. Only authorized personnel have access to the files. The respondents were advised that any material stored by electronic means, such as on a tape recordcr would be used only to inform this research and will not be used for other purposes. The tapes will be destroyed on completion of the study. These criteria were clearly outlined to the respondents on the information sheet and reaffirmed in the consent form. The university data protection officer in the researcher's place of work was approached for advice on the use of written, audio taped and computer assisted modes of information storage and data analysis. The discussion takes into account the issues raised, such as access and storage of files, and the use of computer assisted data analysis (QUADAS).

3.14 The focus group process

The process of focus groups mirror the natural group process in forming and expressing opinions (Kruegar, 1994, Morgan, 1998). In order to set up a safe environment in which participants can share their views openly and candidly, several considerations were taken into account in forming and conducting the focus group. These included:

1. Choosing group members from a relatively homogenous group so that inhibitions in discussion were minimised,

2. Clearly stipulating the boundaries of the discussion,

3. Using questions or vignettes to stimulate the discussion that clearly indicated the topic of discussion.

In order to achieve a degree of homogeneity in the group, recruitment was from among the former students of the WWP module. To allow for the sense of difference, which according to Krueger (1994) enables discussion of a range of views, the range of Community Nursing disciplines, of the CHCN course, were reflected in the composition of the group.

3.15 The development of approach and ideas.

Key to the successful use of focus groups, according to Krueger (1994) and Harvey-Jordan and Long (2002), is in the preparation. This can be subdivided into two sub-stages planning and administrative arrangements.

Planning, according to Harvey-Jordon and Long (2002) is crucial, to the success of the project and ultimately will impact on the quality of the data. This stage includes reviewing the literature in order to have sufficient facility with the topic under review to firstly, decide on the research approach, and secondly to manage the discussion. A factor, which does not seem to be addressed in the literature however, is the moderator's facility with managing groups of people. For example, even in Morgan's (1998) focus group guidebook, he does not mention the skills required in developing a supportive culture, active listening and challenge required of the focus group moderator.

Brockbank and McGill (1998), with reference to the development of reflective dialogue in the learning environment, assert that it needs to address issues of support and relevance to practice. This principle has parallels with this research endeavour. To achieve meaningful collaboration it was imperative that I, as moderator, pay attention to the skills required with respect to engaging with and facilitating a supportive climate for peer

dialogue. This required reviewing my active listening skills. In particular, I was aware of a tendency to 'jump into' conversations before the speaker has completed his/her sentences. I was aware that in order to generate new ideas from the group that I would need to act as a prompt and summarizer of the conversations rather than as a substantive contributor. This proved easier than I had anticipated since I gave a lot of consideration to the planning and prompts for the dialogue prior to the sessions (see appendix 3).

The administrative arrangements for the project included phoning prospective participants, writing letters and arranging the venue to conduct the interviews. In addition, it included a commitment to transcribing the interviews after each focus group in order to provide a focus for further discussion. The completed transcripts were sent to the respondents two weeks before the next focus group in order to give them opportunity to confirm the accuracy of the transcript and initial sense of meaning.

3.16 The focus group as a series triad

The focus group was conducted as a series of three sessions over a six-month period. This is unusual since the literature suggests that focus groups are usually conducted as discrete events (Kruegar, 1994, Harvey-Jordon and Long, 2002). The rational for this approach arose from several agendas:

- The need to develop ideas with the group membership, it developed as a forum for revisiting key ideas and probing and extending the key themes,
- The commitment to establishing a collaborative approach to the research,
- A forum for reviewing the text and interpretation of the transcripts, and

- An opportunity for reflection between sessions.

An unforeseen agenda arose from the group members who perceived the sessions to develop as a support network similar to clinical supervision. They felt that the group developed a level of trust, which enabled them to explore some of their issues in a supportive environment. This could have presented an ethical dilemma since this was not the primary intention of the focus group. However, the group members were able to recognize the opportunity and used the experience to inform the development of their own support networks.

3.17 Researcher lead: The pragmatics

The commitment to a collaborative approach was of paramount importance, however, as the person wishing to conduct the study for my dissertation, I needed to take the lead in initiating and developing the structure for the practicalities of the study. This began by preparing the initial proposal in order to get ethical clearance from my faculty and university. This phase of the study took a lot longer than anticipated since the proposal hit a hiatus within the university process. The notion of ethical clearance had just become a high level concern and the system was overwhelmed by the number of proposals being put forward. Instead of the process taking three months as expected it took nearly seven months. This delayed the sending out of invitations to the participants. It also affected the scheduling of a date for the first focus group since I felt it would be inappropriate to proceed before the clearance was approved. However, the project was approved unconditionally.

In terms of the commitment from group members, it was apparent that some aspects might be negotiated. This included the dates and times of the focus groups. Factors impinging on this aspect of the project were as follows:

- The nature and shift patterns of the respondents, it had been decided not to conduct the interviews in 'work' time for ethical reasons,
- The distance some respondents were travelling after work to get to the interviews,
- The time taken to transcribe the interviews,
- The interval between sending out copies of the transcripts and the time for respondents to review the transcript, and
- The annual-leave period in the summer months.

I therefore took the initiative and set the time and venue for the first focus group. Henceforward we as a group negotiated the date and time of the following focus groups.

3.18 Evolving approach: The development of the research instruments

In preparing for the first focus group, I designed a very structured protocol. This was in order to set the parameters of the discussion, reinforce the nature of the project and affirm the expectations of the group members and to establish ground rules. Since the group was to meet on three separate occasions, might be discussing sensitive issues and the research was to be collaborative, I felt it was important to do the groundwork in establishing the culture of the group. There were some preliminary questions in order to enable the group members to engage with the topic.

The ideas contained within the protocol were pre-tested with two colleagues to check the efficacy and clarity of the questions. As the focus group unfolded, however, I found that I drew on the emerging themes that the group were raising, such as personal growth and risk in developing the discussions.

It was apparent that the respondents were discussing ethical concepts but were not using terminology found in the literature. This realization was confirmed during the transcription and informed the development of the second focus group protocol. Since a key issue was in exploring how Community Nurses engage with and operationalise ethical concepts, I developed vignettes (appendix 5) with a clinical orientation which were designed to 'draw out' ethical principles. Bond's (2000) framework describing those found in relation to counselling practice was used as a prompt for this. This model is depicted in figure three.

It was evident that the Community Nurses were exploring issues in ways that suggest that there were several perspectives in any given situation. This seemed to be dependent on the context, the nature of the intervention and the position of the stakeholders involved in the situation. A theme, which seemed to be central to their specific perspectives was that of integrity.

3.19 Summary of key issues

This research project seeks to discover links between Community Nurses' exposure to and engagement with self-assessment and the ethical principles they employ in decision-making in their clinical practice. A key concern in developing the project has been one of recognizing and addressing the power dynamics within the research relationship whilst

attempting to uncover the dynamic relationship existing between the different layers of social life. I have argued that a postmodern approach lends itself to particular focus being placed on the power differentials within the research project. This infers that full participation by both the researcher and the respondents would be the optimal agenda. This includes decisions by the respondents to join the research project or 'opt out' of the research project at any point. It also accommodates negotiation of the research design, commentary on the data, collection and interpretation of data and contribution to the dissemination of the initial results. The first of these issues has been addressed in this chapter, whilst issues relating to the authenticity, interpretation and interrogation of the data continue to be addressed both in chapters four and five.

A central concern discussed in this chapter is that a research design allowing the research population to be involved in the design and management of the project would 'sit' more comfortably with the topics under consideration. This arises both from the issues being researched, and the commitment of the researcher to developing a collaborative methodology.

In keeping with a postmodernist research methodology that would accommodate these issues the respondents were asked to:

- Contribute to the research design,
- Comment on any material generated as a result of their participation in the study,
- Participate in any dissemination initiatives, which emanate from the project.

To this end a sequential series of focus groups were set up in order to allow opportunity for the generation of new ideas whilst allowing time to address with members the accuracy of the recording and interpretation of the data.

The research question relates to the influence self-assessment has on the clinical decision-making of the individuals who have been exposed to it and have completed their course of study. This focus allowed for invitation to be made to former students who are now in employment. The project was designed to evolve as a negotiated endeavour which 'sits' more comfortably with the nature of the subject of study.

However, this approach incurs risks since the respondents were involved in generating the research methodology and design. The focus groups were used to generate ideas and themes in relation to these issues. This demanded a high level of skill in executing group management as well as in recording the data accurately.

In my view the key aspect of engaging the respondents in the research design was to enable me, as the researcher, to value my colleagues' contributions and expertise, and enable us as a team to develop our research skills. Cowan (1998) argues along similar lines in describing his experiences of encouraging student groups to engage in action research, arguing that this enables them to develop their skills of analysis and self-awareness.

The continuance of this commitment is discussed in relation to the process of data analysis processes in chapters four and five. Chapter four offers the rationale for the approach to the data analysis including discussion on authenticating the interpretation and

analysis of the data. It also discusses the tensions inherent in locating the study within a paradigm which has a tendency to focus on the personal levels of social life.

4 Chapter 4: The Process of Data Analysis

4.1 Introduction

This chapter outlines the process of the data analysis. It identifies the steps of the data analysis including:

- **Step one**: the mechanics of the data analysis, including a review of the implications for the commitment to respondent validation

- **Step two**: the management of large tracts of text and the difficulties of organizing this. This section considers the problems inherent in managing the text and the tensions which emerged by choosing to employ a Computer Assisted package (NUD*IST) to assist the analysis.

- **Step three**: a critical evaluation of the process. This includes a review of the disparity in attempting to adopt a postmodernist approach when working with the 'voices' of others. It also presents the case for reverting to a modernist approach to the analysis of data of the data.

- **Step four**: the use of Layder's (1994) research map in an attempt to address tensions emerging between the evidence of the literature review and the respondent's text.

- **Step five**: Summative review of the trustworthyness of the research an evaluation of the ethics of the research process with respect to addressing the power dynamics within the project.

The chapter draws on Strauss and Corbin's (1998) model of data analysis in order to provide structure. It offers a critique of this choice of framework in addressing the process of data analysis.

Whilst some of the data is included here in order to illustrate the development of the process the detailed account of the data analysis and findings are reported in chapter five.

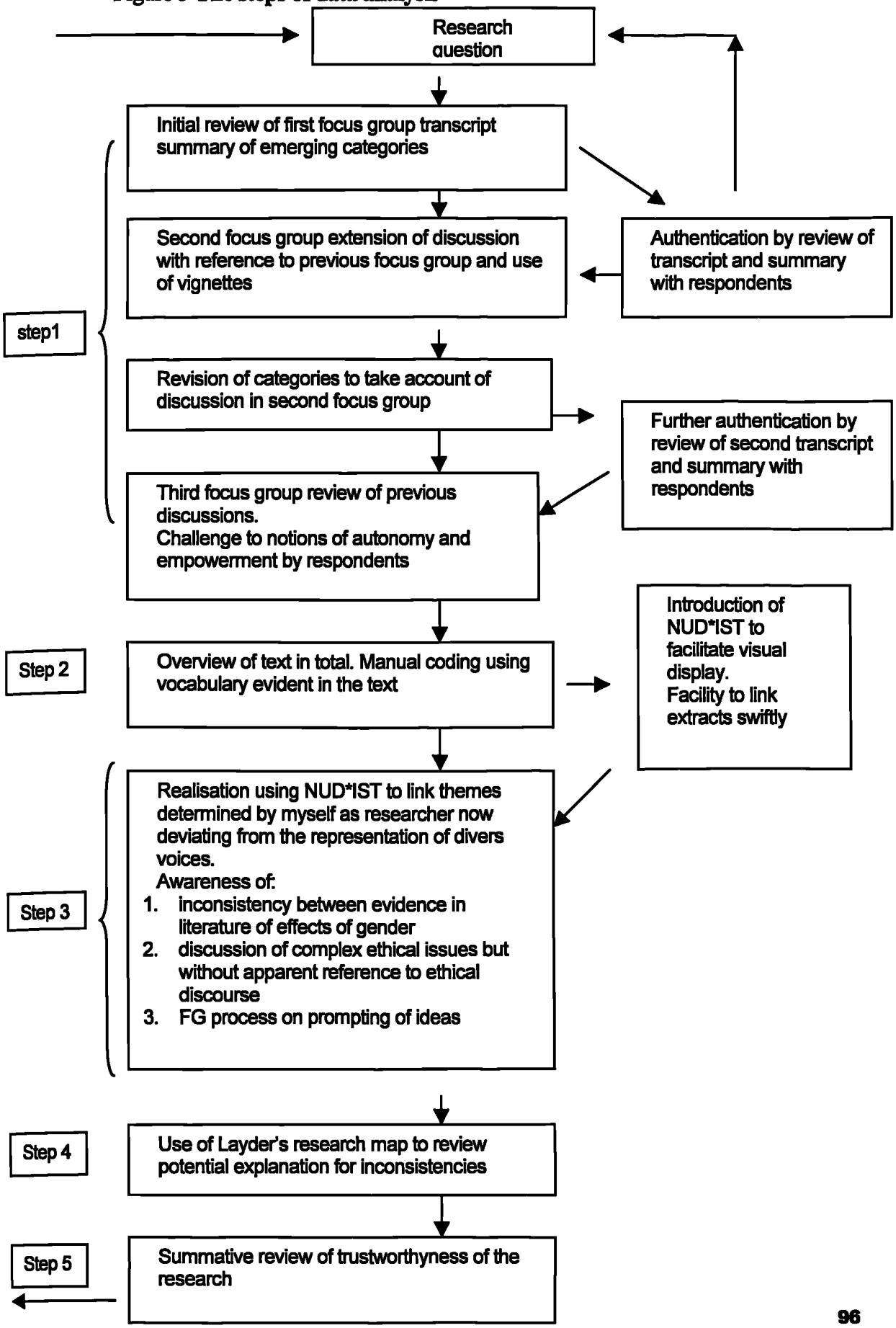
4.2 Rationale for the approach to the data analysis

Coffey et al. (1996) believe that the postmodern movement in the social sciences has provoked researchers to critically evaluate their approach to the reporting and representation of social or cultural phenomena. In this process they argue taken for granted categories and methods of data collection and analysis have become problematic. They go on to assert that it is not necessary to 'endorse the rhetoric and most extreme formulations of postmodern inquiry in order to take seriously the issues' (1996:1). Indeed, they state that more classical versions of sociological or anthropological understanding also offer justification for a re-evaluation of ethnographic representation.

What follows here is a description of my process of data analysis. Firstly, it describes the difficulties both in conducting the initial stages of analysis whilst attempting to maintain the integrity of the postmodern approach. Secondly, it addresses the tensions in managing large amounts of text. The focus group transcripts are a source of rich data however, I found it impossible to maintain a coherent sense of the multiple voices within the research arena in the text I felt I was required to produce. The mere process of analysis that I engaged with meant that I began to produce a type of text with which I was more

familiar. The following account therefore discusses the dilemmas I encountered and the choices I made in conducting the analysis and representation of the data.

Figure 5 **The steps of data analysis**



4.3 Methods of data analysis

In designing the data analysis I began by referring to Strauss and Corbin's (1998) model of data analysis. They suggest that data analysis consists of 'describing, conceptual ordering and theorizing' (Strauss and Corbin, 1998:25). Describing involves telling the story without stepping back to interpret events or to explain why events occurred. Ordering involves classifying events and objects along explicitly stated dimensions without necessarily considering the links between the themes. Theorizing is the act of constructing from data as an explanatory schemes that 'systematically integrates various concepts through statements of relationship' (Strauss and Corbin, 1998:22).

Miles and Huberman (1994:341) argue that there are three aspects, which are a distinct property of the qualitative paradigm:

- It has to be developed in response to the question and is subject to revision as the research proceeds,
- It has a 'life cycle' in which data collection and analysis shift as the research proceeds and the different stages of the study may call for different analytical strategies, and
- The process is inherently cyclical and patterns, hypotheses and themes are discovered inductively. These patterns may be verified using deductive means, which in turn may lead back to further inductive insights.

Miles and Huberman (1994) further suggest that analysis involves three related processes:

- **Data reduction:** the selection and condensing of data based on an emerging conceptual framework. It involves coding and memoing.
- **Data display:** the organized compressed assembly of information.
- **Conclusion drawing/ verification:** the process by which the researcher draws confirms the findings of the project.

Miles and Huberman (1994) also argue that qualitative research designs cannot be taken off the shelf but need to be developed in relation to the presenting problem. They are therefore subject to modification and customized as the research proceeds. Miles and Huberman also assert that qualitative studies have a 'peculiar life cycle' (1994:431) in that the relationship between data collection and data analysis changes in emphasis and this calls into play different analytical strategies as the research proceeds.

4.4 Data analysis as an evolving process

The current project mirrored the stages outlined by Miles and Huberman (1994). Several aspects of the research were crucial in determining the way in which the analysis of the data evolved including:

1. The exploratory nature of the study,
2. The cyclical development of the project in which the data from each meeting informed the themes and discussion of the next meeting, and
3. The commitment to seeking authenticity in the recording and interpretation of the data.

In representing the data I am mindful that the story is crucially informed by my world view as the researcher. Whilst I chose to work with respondents in the design and analysis phases of the project it was not possible to work as extensively with the respondents as this commitment requires. The review of the postmodernist approach had raised my awareness of some of the constraints and assumptions underlying the research process. However, it did not address the dilemma in working with the text of others in the process of data analysis. As described in chapter three, I had made a commitment to attempting to be reflexive and foreground a commitment to collaboration with my colleagues, seeking authenticity of recording and interpretation of the data. I hoped to enhance the personal interrogation of my assumptions and those evidenced in the literature, the difficulty was in representing the text of others. The process of the data analysis in itself made it difficult to sustain the commitment to representing the perspectives of all parties equitably.

In reviewing the data I found that as a researcher I was making strategic decisions about it's content and what it represented. Below I describe how the resulting tensions affected the design of the data analysis.

4.5 Seeking authenticity and trustworthyness in the data

Ropers-Huilman (1999) asserts that researchers in the postmodern paradigm might think of themselves as witnesses located at complex intersections of knowledge. She argues that as researchers we take a part in shaping the discourses in which our research participants and ourselves are situated. Therefore, the task of the researcher becomes one of crafting meaning within discourses and describing events:

> from our vantage points and struggling to paint a picture of the discourses in which we are operating....
>
> (Ropers-Huilman, 1999:23).

The key endeavour of the analysis and reporting of the research findings is, within this framework, one of checking the authenticity of interpretation of meanings intended by those participating in the research process.

The process therefore becomes a collaborative endeavour including self-reflection on the part of the researcher and a process of reflective dialogue, with the research population. The aim was to uncover alternative or new perspectives, which may illuminate the participants' experience of self-assessment and their ethical practice in decision-making in Community Nursing.

Although I was able to meet with my colleagues whilst the focus groups were scheduled this level of contact was not possible to sustain largely because of time constraints and other commitments. As a group the respondents asserted that they would prefer to see the final document since they had other commitments and felt that they could trust me as the researcher to make a meaningful representation of the data. This I felt deviated from my assertion that I wished to consult with the members of the group as the process evolved. This tension reflects Schulz et al's. (1997) concerns about engaging in collaborative research referred to in chapter three. I felt I had to respect the respondents wishes since ultimately this was my endeavour and the research project was not funded.

4.6 The sequencing of the analysis

The process of data analysis was cyclical. Initially this was informed by the commitment to engaging the respondents in the research design, seeking authenticity in the recording and interpreting the data.

Step 1

The focus group met on three occasions. The sequencing of meetings allowed me to transcribe the meetings and to draw out preliminary ideas to discuss with the respondents. In arriving at the summary I reviewed the data displayed in the transcript and looking for descriptive accounts of themes. I was 'attributing a class of phenomena to a segment of text' (Miles and Huberman 1994:57) (see appendix 8).

I sent a full transcript to each of the respondents together with a summary sheet (see appendix 4). These informed the preliminary discussions at the following focus group.

The sequential nature of the focus groups enabled me to engage the respondents in discussion about my perceptions of the themes emerging from the previous sessions. Interestingly during the second focus group the respondents stated that they found it very difficult to read their own text. Since I had transcribed the text and had reviewed it for emerging themes I was able to reassure the respondents and was able to affirm with them their particular contributions to the dialogue. The respondents stated that the summary sheet proved useful and made them think back to what we had been talking about. However, on reflection it is apparent that, as the researcher and moderator in the group, I was influencing the direction the discussion would take since I was introducing ideas and concepts for discussion.

The preliminary stages of determining categories began after the first focus group. Here my concern was in clarifying my perceptions of the emerging themes with the respondents. I was seeking authentication of the transcript and contributions from the members of the focus group in developing the emerging ideas. The categories are outlined in detail in chapter five.

During the period of the focus group meetings it also became apparent that the process of data analysis should not include only the verbatim responses but should also address the process of the focus group interaction. Catterall and Maclaren (1997) draw our attention to the way in which focus group members contribute to discussion and provoke new lines of inquiry. This then brought another level to the analysis in considering how the group process affected the generation of the data.

For example, by engaging with members of the focus group and reflecting on the transcripts, it became apparent that during the three focus groups the respondents' position on self-assessment and ethical frameworks appeared to shift. In the first focus group, the discussion was in part pre-empted by my interview schedule and original assumption that there may be some link between self-assessment in an educational environment and decision-making in the clinical environment. The respondents engaged in this discussion and gave examples of how they have taken the model they learnt about into their management of others within their teams. In the second focus group the concept of self-assessment was revisited to add context. As the response to the question asked by Respondent B 'does everyone self-assess' illustrates:

> Yes, constantly we do. In fact the last person I saw this morning was quite real. Whilst I was doing what I was doing I was thinking – Well, I saw him last week and I should have done this or I should

> have done that ... this is because he keeps coming in on emergency appointments – so you just have to do the emergency thing – and you think to yourself, I should be handling the time and I should be doing things differently and the next time he comes I shall remember to ask him about this or that just to make sure I have covered all the areas. Do you see you do it automatically?
> *Respondent S*

Unlike in the first focus group when the discussion centered on self-assessment in educational and appraisal situations Respondent S is indicating that it is integral to her practice.

The respondent who asked the initial question, then went on to question whether self-assessment is evidenced in other professions as the extract below demonstrates:

> Is it because of the profession we are in? If you put it to someone outside the profession about self-assessment would they come up with the same answers? Would they say that they continually review?
> *Respondent B.*

What we see emerging here is in situ theorizing drawing on experience. The respondents are asking questions of their practice including implicit questions about the nature of professional practice.

By the third focus group, the genre of the discussion had altered and it became apparent that their roles as advanced practitioners demand continuous review and justification of their professional judgements. This latter discussion suggested that the respondents go beyond a model of reflection, which as Moon (2000) observes, can remain at the level of description if there is no mechanism for challenge within the model. The PN for example, recounted that she has no one available with whom to discuss her clinical practice. To engage in a critical review of her practice, she uses a process of self-assessment. This has taken her to a position of being able to critically evaluate her practice and justify her

actions to others within the Primary Health Care Team. (See appendix 10 for more detailed extracts of text)

The development of the focus group dialogue therefore enabled several processes to take place. These included confirming the appropriateness of the research design and affirming and authenticating the data representation and interpretation. The additional characteristic that emerged was the development of ideas about the concepts being studied.

Step 2

Following the transcription of the dialogue of the third focus group I experienced what St. Pierre (1997) as I confronted the vast array of data. I had already begun making tentative categories following each of the first two focus groups that I had shared with the respondents. I now revisited these texts together with that of the third focus group looking to make sense of the texts. Although the manual coding was useful I wanted to find out if there was a way of viewing the text differently which would bring up a different perspective on the texts.

As the process of coding and reviewing the data unfolded therefore, it seemed that the use of a computer-assisted package might enable me to examine the data more comprehensively. A physical display of the data was revealing and had enabled me to explore some interesting themes with members of the focus group. However, it felt that the issues were complex and that there may be links that were not immediately obvious to myself or the respondents. I, therefore decided to explore the use of NUD*IST as a tool to enhance my data analysis. As Barry (1998) observes critics of computer assisted

packages suggest that they can be abused and result in distortion of the data. However, I was attempting to use it in viewing the data in different ways and not for statistical manipulation. Whilst recognising that the use of the package would bring a methodological constraint due to its structure it also could be liberating because of the speed at which it can produce a visual display of data. My concern was that in producing the analysis I would use it in the spirit of the methodological approach.

Seeking a rationale for use of QUADAS became a voyage of discovery. I found myself self-assessing my skills in the use of information technology. For example, what were my keyboard skills and knowledge of commands? How did I relate to the computer technology? Did I appreciate the way in which IT works? As I began to review the literature in the field, I began to realise that not only were there different ways in which the package relates to the data but the package functions in different ways. Was I a logical organized type of person or could I cope with a degree of uncertainty? This latter issue was also a methodological concern since 'Logic' of itself is a social construct from a postmodernist perspective.

4.7 Choice of software

After contacting various publishers of software, it became apparent that they could be very expensive and might require a level of skill with IT that I would find time consuming as well as challenging. I decided to take a pragmatic approach and located the package NUD*IST available to me as a member of the academic team in my university.

NUD*IST (N4) is described as a tool to support the processes and activities in which the researcher engages (Gahan and Hanibal1998). It provides tools to enhance the data

analysis. Its effectiveness however depends on the researcher's engagement with the data. As Fielding and Lee (1998), and Gahan and Hannibal (1998) argue, the question–answer equation rests firmly with the researcher.

4.8 The use of NUD*IST

The full transcripts of the three focus groups were inserted into the NUD*IST softwear. It is quite usual to use relatively discrete extracts of text, such as single words or lines of text when coding material. However, this limited the identification of linked conceptual themes. By using individual speaker's contributions, instead of line by line units of dialogue, it was possible to reaffirm that the respondents were linking complex themes. This confirmed that the respondents were using a range of ethical perspectives even within one illustration of their decision-making context. The process also brought to light words consistently linked in the text, such as dilemma and decision-making.

Since I had previously immersed myself in the data and themes were beginning to emerge, I used the words found in the text, as text searches to review the frequency of these occurrences and confirm the relevance as initial codes. The NUD*IST text search enabled me to review the frequency and patterns of distribution of key words. The next stage was to link these extracts to nodes so that the package could be used to identify links between themes. The package did this swiftly and it was then possible to scan sections of text to look for other words used to describe or confirm the concept being reviewed. Although it is possible to do this by manual means, the computer package brings up the relevant sections very swiftly which saves hours of pouring over the text. As Barry (1998:1) asserts, this opportunity to generate searches quickly 'livens up' the research process. However, she also cautions the misuse of such packages where they

have been used to produce superficial levels of analysis, for example, by reducing the data to a number crunching exercise.

The text search complimented the development of the system of nodes which represent the coding system in NUD*IST. As the themes emerged they were identified as nodes and as nuances emerged from the text child nodes capturing these differences were then developed. NUD*IST can display these nodes as a network diagram allowing one to review the emerging categories looking for themes and associations. It can also generate a list so that one can look at how one is categorizing and sub-categorizing the data at a glance (see appendix 7). The use of NUD*IST therefore, made it even more evident that the data was complex and I felt I needed an analytical tool which would enable me to attempt to explain some of the dynamic nature of the text(s).

4.9 Critical evaluation of the process of data analysis thus far

Step 3

As the process of coding and interpreting the data unfolded, it was apparent that there were a range of meanings and possible interpretations of the key themes. This had been illustrated during the focus groups as members of the discussion asked for clarification of some points and challenged other's perceptions of events. It was also clear that I had made assumptions resulting from my own personal trajectory including socialization both in Community Nursing practice and in within a HE setting. On reviewing the data sets, I noticed that I was grouping a range of data under the themes. However, the text did not necessarily replicate the same language in each event. Ethical concepts in particular were emerging but unlike when discussing technical procedures the Community Nurses were

not using the technical language of ethics to describe their deliberations. However, was I making assumptions about meanings? I therefore sought a framework that would allow me to raise critical questions of the process and the data.

However, whilst moving through the process of this dissertation, I found myself questioning the way in which I have undertaken the study. The disquiet I have been experiencing emanates largely from the contradictions between attempting to take a postmodernist stance whilst working within a context in which language may be seen as unproblematic. The endeavour became one of attempting to interrogate meanings whilst producing a coherent discussion.

Nicholson and Seidman (1995) draw our attention to the difficulty of the postmodernist challenge of assumptions of self as an unified or coherent whole. As the literature review revealed, both self and assessment are consistently unproblematised. Similarly, within the focus groups texts the respondents consistently used what might be perceived as specialist terminology as shorthand to convey their sense of perceptions of identity, for example, in describing themselves as a CPN or a DN. When questioned further, members of the group were able to illustrate their perception of the terms they were using to describe themselves or each other, and indeed this did result in challenge between them about the underlying assumptions implied within these terms. For example, the DNs challenged the dominant public perception of their role being predominantly about giving direct nursing care to older persons. They elaborated on the complexity and range in their roles, such as managing, delegating and working with other agencies and carers in developing and supporting care packages. Their analysis largely centred on their experience in practice, but also referred to the policy changes affecting their roles and the interface between primary and social care

agencies. This element led to an exploration of what they described as the lay perception of DNs as care givers providing a service considered to be free at the point of contact. The DNs also gave examples of their conflict of interests since the notion of care has been redefined so that some care that was previously categorised as nursing care now falls under the heading of social care. The DN's described situations in which conflict of interests has occurred and they were not able to resolve the situation. This may have been due initially to resistance by the client who subscribes to the original view of the DN role. They have then resorted to waiting for a situation in which their resources have been stretched to the limit in order to argue that they are not able to provide the service. This has left them feeling uncomfortable since they can appreciate why the client holds his/her view of the service (The discussion is detailed in appendix 9).

It was evident to me that a range of factors influenced the process of the Community Nurses' decision-making. These included:

- The expectations of the client,
- The nurses perceptions of their relationship with the clients,
- A sense of responsibility for the welfare of the clients,
- A sense of the responsibility to their wider client groups,
- Their perception of the consequences of their actions,
- The wider societal expectations of the service, and
- Government agendas arising from changes in community care policies affecting the provision of relevant services.

In terms of the ethical frameworks employed, there seemed to be a sense of the personal relationship with the client built up over time. This included a respect for individuals and their perceptions of the roles both the NHS as a welfare agency, and of the particular aspect of service the nurses represented. In the DN's example of disengagement with a particular client, issues of resource distribution and the efficacy of providing a service that was provided effectively elsewhere became a major concern. Throughout their example the DNs made a point of stressing the way in which they would have to work both with the client and with the other disciplines in the Primary Health Care Team (PHCT) and with social services. An important theme that emerged here and in other parts of the discussion was in the relational aspect of their decision-making with an emphasis on optimizing the client's experience. This example illustrates the individualistic emphasis in DN's practice and the tensions arising from the changes in social care and health care boundaries described in the literature (Symonds and Kelly, 1998, Malin et al., 1999).

However, none of the group members mentioned structural issues, such as the gender dimension of nursing practice and its apparent association with the caring role, although this is discussed extensively in the literature. In particular, it is discussed with reference to the professionalisation project in nursing (Porter, 1992, Davies, 2000, Davies et al., 2000, Williams, 2000, White, 2002). This omission may confirm the postmodernist assertion that individuals have multiple identities. However, it does not take into account explanations associated with structural mechanisms and collective experience since these are not acknowledged by members of that group. In focusing on the 'personal', the evidence from studies which examine issues such as the gender disparity in recruitment

to nursing and the disproportionate male/female profile within the administrative structures in the NHS are in danger of remaining 'hidden'. In attempting to overcome normative assumptions associated with explanations of gender or social class in favour of multiple identities, it may be that we negate the influence of structural mechanisms within society. Although they may be beyond the individual's experience of identity, does this mean that they are not worthy of consideration?

Using the example of gender politics Nicholson and Stiedman (1995:27), suggest that if we consider women to be a 'distinct unitary group', which is grounded in some presumed common experience or values, we cannot uncover a sense of the dominant masculine liberal model of citizenship. If in contrast, as Moufe (1995) argues, we conceptualize identities as multiple and sometimes contradictory then we can start to examine politics as focused on specific issues and principles. The issue in nursing then becomes one of interrogating the debates further to consider the multiple tabulations of identity including social class, gender and race and their relationship to personal experience.

The use of language as shorthand, with an assumption that others within the 'community' understand the issues, may also lead to the omission of a critical interrogation of concepts. For example, I assumed that the term mental health client referred to someone who has a mental health illness and is in receipt of mental health services. As the narrative unfolded, it became apparent that a myriad of assumptions inform our use of language and our interpretation of such terms. The shorthand I was using belied a complex matrix of issues affecting the CPN's working definition of a mental health client. For example, the nature of the person's illness, means of referral and the group responsibility for accepting the referral all affect her definition. These assumptions arise

from a range of sources including our personal trajectories together with, as Wilmot (1995) and Malin et al., (1999) argue, our socialization in our professional, education and working contexts. Willig (1999) extends the argument by asserting that the way we use language to categorize people reflects the culture in which discourse is situated rather than the event itself. The question then becomes one of generating ways of understanding the text whilst avoiding essentialism.

As Young (1995) argues, perhaps we should consider identity as a series. This conceptualization is more amorphous and fluid than one of group membership and has no defining characteristics. Membership becomes a passive experience, which both constrains and enables individual actions but does not define or determine them. This may account colleagues' personal disengagement with gender issues. As I began to examine the text in more depth this seemed to be a useful starting point, which might inform my analysis of the text. In order to achieve some sense of coherence, however, I sought a framework which would enable me to explore these multiple and contextual aspects of the respondents dialogue. Arguably, this sense of wanting to use a coherent structure could take me away from a postmodernist analysis. However, my perception was that the postmodernist perspective might negate some avenues of inquiry evidenced in the literature review which were not overtly referred to by the respondents. I therefore sought some way of structuring the analysis without significantly compromising the research approach. Hence, I chose to use Layder's (1994) research map as a prompt to enable me to ask critical questions of the dialogue.

4.10 Theorising the data : Layder as a critical prompt

Step 4

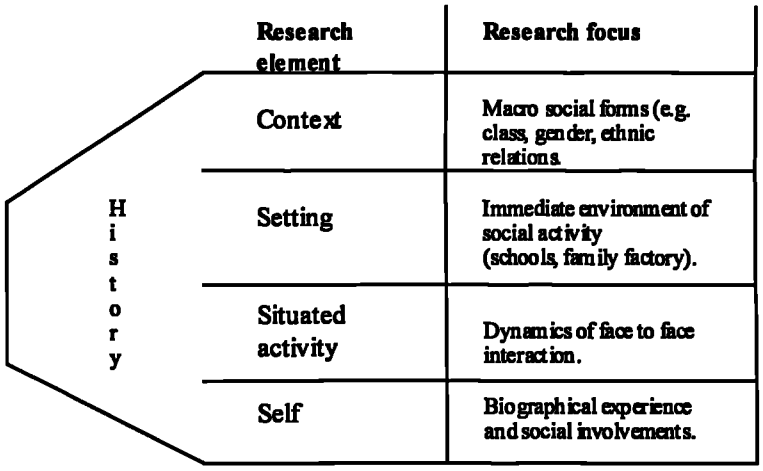
Social reality is textured and interwoven on a range of levels and dimensions (Layder, 1994). Layder attempts to offer a research map that will enable the social researcher to analyse these levels of social reality. His distinctive approach is to encourage the researcher to transcend the limitations of middle range or alternatively grounded theory, which tend to focus on only one or two dimensions.

As the research project unfolded, it was apparent that the discussions within the focus groups were reflecting a range of perceptions that might be open to analysis on various levels. The respondents were framing their perceptions and experiences in different ways. This seemed to be a function of their individual experience, context, and contrasting world-views. The latter might result from differences in their training and experience. For example, their discussions gave a sense of a wider perspective related to images of health and health care priorities whilst also conveying a sense of the organisational issues affecting the particular context.

With these layers of social reality emerging in the text it was necessary to find an analytical framework which would allow the data to be interrogated on a range of levels. Layder's (1994) research map seemed to allow for these levels to be examined in an integrative manner, which would reflect the complexity of the discourse. This is an attempt to develop what Gubrian and Holstien (2000:497) describe as a 'hybridized analysis of reality construction' that co-opts useful insights from a range of traditions.

Layder (1994) refers to the levels of analysis as, the self, situated activity, setting, context and history are intended to enable the researcher to bring together macro and micro analysis together. This is depicted in figure 6.

Figure 6 Layder's Research Map



Research map: (Source Layder, 1994:8)

According to Layder (1994), all the elements of the research map interweave with each other although they all have distinctive properties. The 'self' denotes the individual's relationship to his/her social environment and 'characterised by the intersection of *biographical experience and social involvements*' (1994:9). In the situated activity, the focus shifts from the individual to the dynamics of social interaction. The setting refers to what he describes as the intermediate forms of social organisation, such as schools, hospitals and factories. In contrast, the 'context' refers to the wider social forms that provide the 'more remote environment of social activity' (Layder, 1994:9).

4.11 Review of the trustworthyness of the process

Step 5

The steps of data analysis shown here reflect my difficulties in pursuing a postmodern account of the data. Schulz (1998) argues that methods of data collection should be guided by the aspects of validity which are of most concern to the project. My concern is that this assertion must also extend to the process of data analysis, although I would place the emphasis on ensuring that the respondents meaning is conveyed which involves developing aspects of authenticity. This includes some way of involving the respondents in authenticating the texts and the meaning(s) inferred from them. I attempted to ensure that this latter condition was met. However, it was difficult to sustain the commitment to involving the respondents in the process of data analysis. One might argue that the process became too ambitious for the project since I moved to a position of using NUD*IST and Layder's research map in order to extend the analysis of the data. It would seem however that these tools may have added something to the analysis since they allowed me to review the data in different ways and attempt to step outside my own perspective on events.

Schulz (1999:396) goes on to state that realistic assessment of both the weaknesses and strengths of a research project should help one to remember that humility is a virtue in science. It is apparent that in stating a commitment to a postmodern approach at the outset I might be charged with being very naïve about the complexity of this paradigm. Whilst this may be a legitimate perception I might also argue that by wrestling with this approach I have become more aware of tacit assumptions about the nature of research. I

have also learnt to carefully consider my own approach to research and to find ways of moving through complex dilemmas whilst trying to maintain the integrity of the project.

Tim May (1996 cited in Fielding and Lee 1998) argues that for theory to be shown to guide research practice two conditions must be satisfied

1. It must be shown that that research practitioners hold theoretical commitments independent of their research,

2. It must be shown how such beliefs translate into practice.

(May (1996)cited in Fielding and Lee 1998:182).

Fielding and Lee go on to state that texts which demonstrate this process are rare and that those which do exist are often written in the 'rosy homologizing glow of hindsight' (1998:182). They argue that it is difficult to ascertain whether the bulk of social research is theoretically guided or is driven by a catalogue of pragmatic decisions as described by Platt (1996). They observe that it is more plausible to argue 'that theory is led by practice, just as analysis is moulded by the methodological procedures that make some aspects of the social world available as 'data while concealing others' (1998:183). They offer that justification is usually post hoc rather than pre-emptory.

My approach has been one of attempting to remain in the spirit of valuing the divers perceptions of the respondents but at the same time being mindful of the limitations of a personalized world-view.

As can be seen from the preceding discussion, the process of data analysis adhering to the principles of a postmodernist approach proved to be complex. The move away from a descriptive account to one which would enable an examination of the hidden assumptions and the socio-political context necessitated the development of complimentary tools to facilitate the analysis of the data.

The next chapter endeavours to analyse the data drawing on the process of qualitative data analysis, computer assisted data analysis (NUD*IST) and the application of Layder's (1994) research map outlined in this chapter.

5 Chapter 5 Findings: Presentation of Emergent themes

5.1 Introduction

This chapter presents the findings gathered from the sequential focus groups. Strauss and Corbin's (1998) process of analysing qualitative data is used as the initial model of presenting and interpreting the data. In order to extend the analysis, the themes emerging from the data were then re-examined together with the literature using Layder's (1994) research map to prompt the development of alternative perspectives. It is acknowledged that the type of data collated from the focus group discussions lends itself to descriptive analysis however, the map is applied to raise awareness of the levels of social interaction, which inform discourse. This is then used to extend the analysis to ask critical questions of the dialogue. NUD*IST was used to confirm the occurrence of key themes and as a tool to quickly search the text.

It is acknowledged that the techniques for analysis derive from a modernist tradition and may be in conflict with a postmodernist approach. Whilst acknowledging that Layder (1994) describes his approach as realist it is presented here as a means of stimulating raised awareness of alternative perspectives and interpretations of the data. Thus the literature review is used as a comparison with the ideas and in situ theorizing which occurred in the focus groups. It is also used to illustrate the potential for dynamic interplay between the levels of self, situated activity, setting, context and historical perspective both within the nature of the discourse and ideas expressed by members of the focus group.

The emergent themes presented are as follows:

1. Perspectives on assessment and self-assessment: including the initial presentation emphasizing the educational experience to the significance of the skill has in informing complex decision-making in clinical practice,
2. In situ theorizing, risk, confidence, integrity, support and professional context,
3. Expression of ethical principles,
4. An emerging construct of relational ethics, and
5. A multi-level critique of emerging ethical constructs.

The interpretation of the transcripts suggested six strong influences impacting on these themes:

1. The significance of personal trajectories including socialisation and training on the interpretation of events in situ,
2. The nature of the skills required in conducting inter-personal relationships within a complex environment,
3. Changing constructs of the client/professional relationship,
4. Changing constructs of the interface between social care and health care,
5. Changes in working practices such as inter-agency and interdisciplinary working affecting the perception of dynamics of professionalism, and

6. The contract culture impacting on concepts of accountability.

In order to explore the complexity of the issues presenting in the text, the discussion is framed using the respondents' dialogue on the nature of assessment and self-assessment. This was shared with the respondents in the spirit of authentication and collaboration (Ropers-Huilman, 1999). It then presents a distinct scenario that emerged in the second and third focus groups which was explored with the group members. It illustrates the differences in perspectives of Community Nurses that emerge as a result of discipline specific professional culture and, organisational, contextual and historical factors.

5.2 Perceptions of assessment and self-assessment of learning

The discussion will firstly outline the respondents' views on assessment, then self-assessment and draw comparisons between the emerging themes. The respondents over the duration of the three focus groups discussed assessment with reference to their role in assessing a student, to their own learning and in assessing clients. These examples illustrate a range of concerns impinging on the various contexts.

Several themes emerged in the discussion on assessment. These included:

1. Accountability,
2. Objective measurement,
3. Risk,
4. Confidence,
5. Support, and
6. The nature of the relationship with others including the client, carers and the student.

These themes were also apparent in the discussion on self-assessment but the emphasis was different. This will be demonstrated with reference to the respondents' dialogue.

The themes did not emerge as distinct categories, but were part of a complex arena affecting the respondents' role both as practitioners and as assessors of students. Implied throughout the discussion was a responsibility towards both client and student. There was a different emphasis depending if it was assessment or self-assessment being discussed. Within the context of assessment, a key element seemed to be that the practitioner should be in control of any assessment opportunity. For example, respondents stated that:

> There is that thing that it will come onto, back like to your accountability. For instance,.....if you assess a student as a pass and in fact they are not there is an element of risk and you know that if that person isn't a pass that would be a risk and accountability and it is about being clear
> *Respondent S*

> There is a balance with safetyness
> *Respondent* B

> If I ask a student to go and see a patient to carry out a task then I would assess that risk as to what could go wrong if they made a mistake. If clinically that is dangerous then base that assessment on the ability to do that. It adds caution.....
> *This respondent continues:*
> Whereas if I am assessing something which didn't involve a task or perhaps they end up doing a big piece of work and have gone down the wrong track which is retrievable which is annoying but it is retrievable, then I would be prepared to take the risk. There is a balance of the outcome
> *Respondent J*

As the extracts demonstrate, when talking about assessing others the respondents were grappling with a range of issues. These included:

- Difficulties in ascertaining what is to be assessed,
- Developing a sense of the students capability prior to delegating a task,

- Reviewing their own knowledge and understanding of the situation prior to delegating to another,
- Weighing up the potential consequence to a client or the student should there be an adverse outcome, and
- An awareness of assessing within an organisational context demanding an account of their judgement in both delegating an aspect of client care and in informing a judgement of another's skills.

Respondents were also referring to accountability in several dimensions:

- With respect to their own accountability in managing and delegating care,
- In assessing another,
- As representatives of their employing organisation, and
- As members of a professional body.

Within the discourse both the context of care delivery and managing a student's assessment opportunity there was a sense of protecting the client and the profession in maintaining the standard of care. This tempered is by an element of risk in ensuring client safety and in making the judgement of the student's achievement. As the second excerpt shows, it was evident that there was a tension between allowing students opportunity to practice whilst maintaining the client's standard of care. This arose from the Community Nurses' perception that their primary role is in providing care to clients, the educational role of which assessment is a part was secondary. It was clear that assessment in this context was perceived as something over which the assessor had control and is accountable for the outcome.

The ethical principles evidenced here seemed to be informed by a range of concerns. The principles in part mirrored Bond's (2000) themes of respect for the individual, beneficence, non-maleficence, justice, fidelity and self-interest. However, the respondents did not describe the events as a one-to-one relationship, but as a set of relationships. They also inferred a sense of responsibility to all the individuals affected in an assessment situation including the client, the student and themselves. In terms of the responsibility to the client, there was a general awareness of delegating care to a student under the auspices of the Community Nurse's own accountability and duty of care. This also implied that they should ensure no harm should come to the client.

These principles also extended to the student in that they were to be offered learning opportunities that would enable them to develop. There was also a sense that if no harm would come to a client then the student could be allowed to make mistakes where this situation could be retrieved. As Respondent J's extract demonstrates, in describing the effect on the student, the emphasis was on the opportunity to retrieve the situation should the student fail to choose an appropriate course of action. It is clear that the respondents were using a range of skills in balancing the tensions between protecting the interests of the client and promoting the learning of the student.

The respondents were using a range of skills and knowledge in undertaking assessment of students in the workplace. This related both to the client and student situation. These were used to inform their clinical judgement of the client's context including assessing the physical, psychological and social context. This also included the development of a relationship that might extend to acceptance by the client of care by a student.

By implication the Community Nurses also asserted that they would informally assess the skills of the student prior to asking him/her to undertake a clinical task unsupervised. A sense of the policies and procedures of their employer also underpinned this process of filtering information about the situation. This included both commitment to the duty of care to the client and an evaluation of the practitioner's expectations of students in the workplace.

There is evidence therefore of a dynamic related to the relationship the Community Nurse held both with the client and the student. There was also a complex process of filtering aspects of the information prior to an assessment event designed both to minimise potential harm and to optimise opportunities for the student.

Throughout this part of the discussion there was a sense that the assessor maintained power on a range of levels:

- As guardians of the nursing profession,
- As the nurse accountable for the client's care,
- As the person with authority to delegate care,
- In determining the criteria in situ for achievement, and
- As the judge of the student's achievement.

There was a definite sense of the assessor in control. The responsibility, accountability, and the decision to take risk rested with the assessor in allowing the student access to clients and other assessment opportunities, and in contributing to the judgement of the student's achievement.

In contrast, in discussing the concept of self-assessment the emphasis was on the student's responsibility and engagement with assessment. Key themes evidenced in this part of the discussion were the notion of the student's confidence, propensity to take risk and the need for a supportive environment in which to develop a sense of one's own skills. When discussing their own experience of self-assessment the respondents offered the following insights:

> You have to have a willingness to do it, you have to have the confidence to do it ....If you don't have the confidence to say oh well I can do this, or I am not very good at that then I don't see that it could particularly work
> *Respondent B*

> It works with reflective practice, I find you can reflect on what you are doing and make a *judgement* on how you do it best
> *Respondent S*

> I think some people develop it naturally but others find it difficult. Some people have to have it explained and perhaps have to work harder at it.
> *Respondent T*

> What I do think is that your confidence is challenged you may wish to say well that was one of my weaknesses it can be a strain. I think you could do quite a lot of harm. I work with a lot of people with low self-esteem who lack self-confidence and the slightest thing.- You have to be very careful because they will disappear, they will disengage
> *Respondent A*

> It depends on the support we get. It feels to me that you have to take a big risk that you need to develop and if you don't get the support there you can get like a can of worms
> *Respondent B*

> You need to trust that person that you are doing it with
> *Respondent C*

Here, accountability is seen as integral to the learner's role in that they should be able to make a judgement on their own performance. Similarly, in describing their experience of

self-assessment the sense of risk changed to one of enabling the student to feel comfortable with supportive challenge. The aim was perceived as the enhancement of the development of self. The process by which this is achieved however may be difficult, for some it requires more specific guidance particularly if it does not match their prior experience. Key concepts contributing to a positive experience of self-assessment were a sense of trust together with the notion of support. This suggested that the model of self-assessment being discussed demands commitment both from the student and those supporting his/her development. In this latter discussion the principle of self-interest as a student has a more prominent profile. This contrasts with the notion of assessment in which the Community Nurse, as the assessor, had the responsibility for controlling the assessment context. As the following extract demonstrates in an interview to probe this finding Respondent E suggests that the student moves from a passive participant to one of active engagement in reviewing his/her development.

> Self-assessment means that now I can sit back and really think why would I give myself that mark. It is to do with the drive to want to do better and also the skill of critical thinking and weighing the positive and the negative...Self-assessment is about active learning. Also for me in our group we all went through the group process and we were all very supportive and felt for that person
> *Respondent E*

Within the discussion on self-assessment the notion of harm to the student undertaking assessment is fore grounded in contrast to an emphasis on harm of the client evidenced in the discussion on assessment. Also there is a sense of the subjectivity and engagement with the assessment process rather than one of a neutral 'objective' tool referred to in the previous part of the discussion.

Arguably, this change in dynamic offers the potential for the person engaging with self-assessment to gain more control of their self-development. This was also evident when one of the respondents went on to relate how she had used the model in enabling a colleague in practice to determine their own criteria in the workplace. This colleague was someone who had been re-deployed from a high technology area in a hospital setting.

> I have a member of staff who....we were hoping that she would bring out three specific points, and she actually brought it out to us and now we can work on those, and ask where do you see yourself now for her then hopefully to develop into a safer practitioner
> *Respondent B*

There is still an emphasis on developing the 'safe' practitioner, but there is also a sense of providing prompts and support to enable the colleague to gain insight into her own practice. In later discussion this respondent went on to say that it was very difficult to sustain this approach due to other commitments and poor staffing levels. In addition, the colleague being supported had not experienced this model of working in the past and it did not match the culture of her previous employment situation.

A challenge to the notion of self-assessment also emerged. One respondent saw it being adopted in the workplace as a tool to determine one's way of thinking:

> You could argue that to start to bring out self-assessment its about being told that you need to develop in that way...I also feel it has been used - well it has been done to death. When you go for an interview they say well what are your strengths and weaknesses. I think that becomes a game then. It doesn't become an honest question because you have to have enough strengths to get the job but just a few weaknesses to show you are human
> *Respondent J*

This assertion reflects the tension inherent in what is perceived as a private aspect of development becoming a requirement of formal assessment. This type of discomfort with

a requirement to present private thoughts publicly is described by Hollingsworth (1997) as a disquieting experience. It requires a huge commitment and openness to redefining one's perception of self and the events with which one engages. Hollingsworth (1997) recounts a personal trajectory in which she was socialized into a positivist research tradition, which renders the self invisible, prior to commencing action research. The respondents in this study were socialized in nursing which has a strong association with medicine, and thus with scientific and rational thought (Lister, 1997). Some of the Community Nurses work directly with consultants and GPs, who have a direct influence on the development of their practice. There are therefore parallels in the socialisation process, which affect the way in which such initiatives are perceived.

Respondent J went on to say;

> You see I think it is very important that the module leader or anyone else does not undervalue this personal reflection, private reflection, private self-assessment because it does ... there is this tendency to dismiss it - that doesn't count because it isn't down in your diary or you didn't come to this meeting today. You know that is a bit sad.
> *Respondent J*

Here it became apparent that the concern is not with self-assessment as a concept per se but with the manner in which private deliberations are brought into the public domain. There was perceived to be conflict between the institutional and personal context of self-assessment. In terms of the institutional adoption of self-assessment there was a sense that within the employer-employee arena it is associated with a requirement to publicly affirm one's skills within a climate of culpability and blame. Personal accountability is seen as a key concern of the institution and the agenda is one of continually justifying one's decisions. This contrasted with an espoused view of self-assessment contributing to

individual development within the educational setting. However, within the educational setting there were concerns about the impact on the individual if the commitment by the student is undervalued or dismissed if the form of presentation does not conform to expectations of peers and academics. A key concern was the respect afforded personal deliberations by others reviewing it.

These comments reflect the dilemmas in the literature about the nature and purpose of both educational and clinical assessments. Following Broadfoot (1999), the respondents infer that there are two agendas, assessment is a means of a measuring of performance in contrast to that of informing learning. They also demonstrate differences in engagement and power dynamics between student and assessor within the contexts of assessment and self-assessment similar to those described by Hinnet and Thomas (1999). These authors assert that assessment serves a range of pedagogic interests, which affect the development of assessment strategies. The respondents reflected these debates referring to agendas seeking to ascertain 'objective' measures of achievement in contrast to those seeking the development of the 'lifelong learner'. These tensions were also apparent with respect to the development of tools to assist clinical diagnosis and inform treatment, the inference being that these aspects of health care can be objectively measured. The emphasis is on responsibility and accountability that is influenced by the growth in litigation and regulatory systems within professional contexts.

The context of clinical practice, which is subject to immense change, also impinges on the experience of assessment processes. One practitioner, for example, commented on the rate of change and increasing numbers of technology dependent children now nursed in community settings. This is affecting the need to develop ways of addressing issues of

skill development, such as assessing the home situation and educating young people in managing their own care, in line with accountability. This perception was affirmed in the literature review (Richardson, 1996, Symonds and Kelly, 1998). Another respondent related similar concerns regarding changes in the legislation regarding clients with mental health problems. Both felt these changes, directly affect their practice and their work with students and with clients.

Assessment of practice was therefore, perceived to be part of an ongoing process informing learning. This mirrored the perception of assessment evidenced in the professional literature (ENB, 1993, 1996b). The respondents however, distinguished different responsibilities when discussing assessment in contrast to those experienced in the context of self-assessment. They were the guardians of practice whilst in the context of self-assessment, the onus transferred to the student or colleague engaging in self-development in determining their own judgement of their practice.

Boud (1999) asserts that it is only relatively recently that the nature of decision-making in practice has become a central agenda in professional education. He argues that although practice placements have been an established part of the curriculum for years the notion of socializing the student into professional thinking is new. In the examples cited the respondents seem to infer that they had a higher level of emotional engagement with professional decision-making when they are asked to judge their own skills and experience. This type of engagement with learning in the professional context may contribute to the student's development of skills in ethical decision-making.

However, the comment made by respondent J (page 125) provides a caveat to the efficacy in practice of self-assessment. She is skeptical about the motivation for encouraging students or colleagues to make overt statements about their skills to someone in authority. A similar concern was expressed when another respondent offered that:

> The Hyland Donaldson *(a tool used for self-assessment in practice)* was not particularly held in great esteem and self-assessment wasn't held in such high esteem as how you (*as tutor*) see it and I think it is about how you work although we are continually assessing it's a very different thing that we assess and because we have such different approaches that to be honest the Hyland Donaldson was a kind of whip whereas for you it was used as a constructive tool
> *Respondent B*

Here the respondent again raises issues about the efficacy of conducting self-assessment within a culture that does not appear to subscribe to a philosophy of equality in relationship between the assessor and the student. Here self-assessment has been experienced as a punitive model imposed on the student. In contrast, this same respondent has also experienced it to be one in which respect for the individual's development is a key agenda. Interestingly, although this respondent had had a negative experience of self-assessment she was the respondent who has taken the WWP model of self-assessment into her workplace in supporting her colleague's development.

These examples of perceptions of the conduct of self-assessment reflect the way in which institutional conversation practices are locally organized. Following Silverman (1997), they illustrate how power relations are located within institutional discourses but mediated and constructed within social interactions. In this illustration the adoption of the Hyland-Donaldson model is advocated within the course validation and assessment documents as the preferred tool to prompt self-assessment in practice. However, the

practitioner as a student was aware of a tension between the educational statement and her supervisor's attitude towards it. Here the institutional discourse of HE suggests a commitment to self-assessment of practice. Self-assessment is proposed as a tool to assist critical enquiry however, the personnel supporting educational development employed within a different organisational culture within the practice environment do not apparently subscribe to the same philosophy.

The organisational culture within which Community Nursing is situated and which supervisors are socialized into continues to reflect vestiges of a hierarchical structure. In addition, as reflected in the nursing process approach and the adherence to the medical model it continues to be dominated by scientific/rational perceptions of the care environment. Although as Kelly et. al. (1998) assert, within disciplines such as District Nursing there is an espoused philosophy promoting a move towards a community health needs approach there is little evidence of this. They suggest that although the Ottawa Charter of 1986 (WHO, 1986) provided an initiative to move towards enabling, advocacy and mediating health choices this model has been slow in being adopted. Kelly et al. (1998) argue that the medical model continues to predominate and requires a lesser degree of critical appraisal and informed decision-making than does a model which strives to address power differentials within the care setting.

Costello et. al., (2002) argue that the dissemination of decision-making to lower level workers within organisations is an international agenda. As Lister (1997) observes this change to flatter structures and devolved decision-making is now a feature of the NHS. The dominant model evidenced that fosters dependency and hierarchical structures is becoming redundant. What we therefore see within the practice setting is a clash of

cultures and agendas which individuals may be finding difficult to resolve. The student is therefore exposed to a range of potentially conflicting agendas within the HE and practice settings.

One of the respondents who works in an isolated context gave an alternative perspective:

> But I think it is much more if it (*reflection*) is called self-assessment because I work in a much more isolated way on my own. Self-assessment is a tool which I had never really come across before. But it is really useful to someone who perhaps doesn't often have a chance of being in a position to bounce off ideas. So coming into a classroom situation and being able to reflect with other people who were my peers with no hierarchy, I think that was important so that I felt everybody was doing this so that was a tremendously important point.
> *Respondent S*

This respondent appears to be reflecting a positive interpretation of self-assessment as a tool that enables her to critically review her practice. She had developed her skills in self-assessment as a part-time student in which she was able to use her peer group at university to hone her skills. She continues to use these skills in practice having now completed the course. This respondent works in an environment in which, although she is a member of a Primary Health Care Team, she does not directly relate to another practitioner of her own discipline. She therefore uses self-assessment as a means of self-challenge to prompt her to critically review her own practice. This respondent felt that this went beyond reflection since in her view the way in which she had been introduced to reflection did not necessarily prompt her to judge her performance. Moon (1999) similarly suggests that reflection can remain at this level if it is not provoked by some form of challenge. Brockbank and McGill (1998) believe that practitioners require time away from the workplace to engage in reflective dialogue in order to develop their critical awareness of their situations. This seems to be what this practitioner has done and has

then integrated this way of thinking into her practice where she has less opportunity for peer dialogue.

There are therefore several very different and potentially competing agendas perceived to be affecting the implementation and adoption of self-assessment strategies. These are informed by the perceived intentions of the implementation and the context in which the assessment and self-assessment discourse is situated. Within the nursing clinical practice setting there continues to be an emphasis on rational/scientific endeavour (Lister, 1997). Assumptions of assessment as 'objective' and 'other' are therefore, sustained. In the contemporary context however, where organisations are developing flatter structures resulting in devolved decision-making, which is dependent on an inter-relational framework, conflicts are beginning to emerge. Costello et al., (2002) argue that in this type of business culture more critical thinking skills are required from a wider range of personnel. In addition, models of care which seek to engage clients in empowering and partnership approaches to care suggest that the onus of professional responsibility must shift to a sharing of responsibility.

In contrast, some colleagues in the HE environment are perceived to espouse a commitment to a humanistic tradition of student's self-development although the respondents see this as being tempered by experience and commitment. However, this image of self-assessment equating with the humanistic perception of self as the protagonist in defining self seems inadequate within the contemporary context. Assumptions of self-assessment as a self-referenced activity is inadequate.

These perceptions of competing agendas affect the individual's perceptions of self-assessment. In re-examining the concerns of Respondent J's self-assessment was seen as integral to her judgement, however, the way in which it was being forced into the public domain was causing her distress and concern.

In a later focus group this respondent illustrated the complexity of her assessment of learning with reference to a family situation where a young person is being assessed to carry out complex, high risk tasks such as the administration of intravenous therapy at home.

> But the child may also have the ability to carry that out themselves. And if the child is able to carry out that themselves and show the competencies, and more understanding than the adult can - well we must let the child do those things even if the adult carer is not involved in it. But you must be sure that the parents are allowing that child to get on and do that and not hamper them and be an obstacle making life difficult for the child - because they themselves don't want to do it so they don't want it to be in the home, because that creates a more dangerous situation.
> *Respondent J*

Here we see the Community Nurse is balancing a range of stakeholder interests in order to optimize the care of the young person. She has to assess not only the understanding and ability of family members to carry out the task but also the wishes of both the parent and the child as to where and how treatment is carried out. It is evident that she requires the participants in care to feel confident in administering treatment in the home. In this example she is asserting the rights of the child in conducting his/her own care but also paying heed to the potential for sabotage of this from family members. She is also committed to enabling family members to develop the required skills and competencies. In probing this example further, it was apparent that the move to administering complex

care in the home was a result of other agendas such as increasing emphasis on family centered care. This means that the professional agenda has shifted to one of expectation that care in the home is the preferred option. Another agenda was in minimizing resource costs in hospitalisation. This again was resulting in an emphasis on care in the home. This nurse was therefore negotiating range of agendas directly influencing her practice, not only those overtly evidenced within the client-nurse situation.

When asked whether the decision is irreversible this was her response:

> Well no it changes and we reassess it each time and sometimes you need to read the situation and then make a suggestion. For example, I have a family now who are doing quite extensive home care IV therapy which is quite complex with drips and several times a day.
> I know they have taken that on but I felt that you can sense that this is going to put pressure on the family so I said well lets start off at home and have the child in at the end of the week and lets see. Although she wasn't able to see that at the beginning by the end of the week you know that she is going to be tired out and that is when people are going to get fractious and that is when mistakes start to happen.
> So you can put those suggestions and if she comes back to me and says no we will be fine, I will say than lets see by the end of the week and if you are fine, then we will go on with it at home but if you are feeling tired then we can review it.
> ....
> You do sometimes get a child who demands from its parent you can do that at home and the mother has a real needle phobia and cannot stand the thought of doing it, so you sometimes have to be an intermediary between the two of them. Or you have a parent who wants the child to go home and the child doesn't feel safe with the parent and that is quite a difficult one. You get that sometimes where the child feels safer in hospital than with the parent. But it usually resolvable you can get a balance somewhere along the line without being confrontational about it
> *Respondent J*

Here the nurse is balancing a range of issues and using her experience and specialist knowledge to enhance the family's experience in a non-threatening way. There is an underpinning concern that the procedure is carried out in as safe a manner as possible. In

addition, the respondent is cognizant of the family dynamics and the potential physical and psychological impact of carrying out these types of procedures in the home. This respondent also demonstrates a high level of commitment in enabling members of the family to attain and sustain their role concerning care.

It is also evident that this respondent as a specialist Community Nurse negotiates with the hospital sector in order for the client to be admitted to hospital should this be a requirement. This illustrates a shift in responsibility for hospital admission to a nursing role albeit within the constraints of a prescribed protocol. Here we have a sense of the flatter hierarchical structures developing within health service contexts. This nurse has to engage with a range of agendas which require the high level of critical thinking and analytical skills referred to by Kelly et al. (1998) and Costello et al. (2002).

A range of issues were perceived to influence both educational and NHS agendas. These included working in a climate of continual change whilst providing more complex care in the home. This is usually carried out by informal carers with support by professionals, this together with a move towards client empowerment and partnership working necessitates working in different ways with both colleagues and clients. This commitment to client partnership working and enabling the client to take responsibility is reflected in the following extract:

> It is like you can offer the world to a patient, but it is even more satisfying if they come back to you after a while and say you know can you do this and how do we go about that. Because you realise then that what you have actually said they did take on board and it has taken a while for them to decide and make that decision
> *Respondent B*

5.3 Risk

As the extracts show, the respondents' engagement with self-assessment seems to be linked with ideas of risk and the individual's propensity to take a calculated risk. Risk seems to be a significant issue for the respondents both as the person undertaking self-assessment themselves or alternatively when guiding someone else. The way in which risk is experienced seems to be dependent on the respondents' supporting networks, the cultures in the environment and the nature of the area of work being delegated. In later discussion it was also perceived as integral to a health service culture in which as Kemshall (2002) asserts, change is a constant feature.

The idea of risk appears to be associated with the individual's sense of confidence and his/her perception of their ability to make professional judgements. It was seen as a positive attribute rather than a negative one.

5.4 Confidence

Confidence as an attribute was perceived to be developed with support from others. Members of the focus group saw this as being principally peer support which they had experienced within their focus discussion groups during the CHCN course. It could also be developed and modified with support from peers, tutors and community practice teachers.

As illustrated above, one member of the group had moved on to develop self-assessment with a member of staff. She was encouraging the member of staff to develop her own self-assessment criteria. She had found that support and guidance were key elements of enabling another to develop the skill. However, the comment that the colleague had never

previously experienced this way of working suggests that the concept of self-assessment was not part of her prior working culture.

5.5 Support

Anxiety over self-assessment and the way it is promoted and conducted within the educational environment again became a topic of discussion within the second focus group. It was apparent that issues of safety and support were very important to the respondents. The system of networks that were put in place to assist the student in engaging with this concept during the WWP module was important to the respondents. Hollingsworth (1997) reports similar concerns in her development of reflection within action research. She refers to the supportive culture she was able to engage with whilst undertaking action research.

Interestingly the theme of developing supportive environments and networks also emerged as a theme as colleagues discussed their relationships with others including members of their work teams and with clients. It was apparent that the members of the focus group had a commitment to establishing a rapport with others and enabling them to achieve to their optimum level of skill.

5.6 Commitment to the idea of self-assessment: Implications for the award

In the last focus group the respondents stated that in their experience my commitment to self-assessment, as module leader, was key in promoting their interest and willingness to engage with the concept. This was particularly significant since they did not perceive all members of the tutorial team to have the same level of experience or commitment to the concept.

As Respondent B (page 127) suggests, her engagement also proved difficult since, in her view, it did not seem to be reflected in other aspects of the award. Although according to the validation of the award, students engage in self-assessment using the Hyland Donaldson rating scale in developing their clinical practice, students had differing experiences of the perceived relevance of this. Some felt that it was not used constructively in practice.

Within the self-assessment initiative this sense of disquiet about agendas informing self-assessment initiatives have resulted in promoting a sense of anger with the process. Although one respondent is left with this sense of anger about the formalization of this process, one infers from her account that she continues to see self-assessment as an essential aspect of her ability to function as a competent professional.

This sense of anger with what may be conceived of as an empowering strategy in education is reflected in Costello et al's. (2002) account of developing self-directed learning. These authors suggest that in a context of flattening organizational structures, students on business management courses need to be responsive to their own learning and become active learners in class. However, they report that in making this transition students experience 'trauma, grief, shock and denial' (Costello et al., 2002:118). This difficulty is compounded by the traditional pedagogy the students are likely to have encountered previously and may even be experiencing in tandem with new types of learning and teaching strategies.

A significant point is that whatever the difficulties experienced in engaging with empowering strategies in organisational structures this form of engagement is a

requirement of interdependent relationships within a flatter organisational structure. This together with the agendas for advocacy, empowerment and mediation invoked by the Ottawa Charter suggests that curriculum developers in HE need to foster skills, which will enable the graduate Community Nurse to engage in these types of working.

5.7 Implications of self-assessment for professional practice

Self-assessment appears to be emerging as a core concept informing complex decision-making. There were perceived to be conflicting agendas affecting its implementation both in the HE environment and in the practice areas. However, the way that the respondents were talking about their experiences suggested that they do engage in critical review of their practice on a regular basis. This seemed to emanate from a sense of optimizing the client's experience within a complex care environment. This was illustrated by the examples given above, the core themes of which are summarized below:

- It is a skill which enhances critical review of decision-making,
- It is useful in enabling peers to appreciate the dynamic nature of their responsibilities in care,
- One member of the group has found it a key tool in evaluating her work in a context with limited opportunity to review practice with others,
- One finds it an extension of their practice and related to clinical supervision, and
- One sees it as part of her philosophy of care review.

The two caveats are as follows:

- It takes time and commitment to develop a climate of trust and support in which to promote self-assessment, and
- It is perceived as a tool that could promote a blame culture since it requires individuals to identify areas of weakness as well as strengths.

The DN members of the group seemed to find self-assessment a less obvious form of review, particularly if they work in a team which is focused on 'clinical' tasks. This is associated with the culture of review, the pace of the work and nature of decision-making. There was a also a perceived difference between their experience in the HE environment where time was set aside and supportive peers were available to encourage self-development. This experience contrasted with the pace of work in clinical practice in which they perceived that there is little respite for reflection. This experience may also reflect the continuance of task orientated practice described by Ross and McKenzie (1996) and Symonds and Kelly (1998).

There were also concerns expressed about the way in which reflection and self-assessment are expected to be overt practices. This is with specific reference to the nature of evidencing learning in academic programmes.

The themes described above which were emerging from the data were affirmed with the respondents. These included:

1. Perceptions of assessment and self-assessment are affected by:
    - The personal philosophy of the respondents relating to assessment and self-assessment, and

- Perceptions of the experience of self-assessment within the HE module and in practice settings.

2. The context in which self-assessment was being practised is mediated by:
    - The clinical discipline of group members,
    - The clinical context, and
    - The motivators for implementation.
3. The support network within the environment in which self-assessment is being practised affect the development by creating:
    - Opportunities for peer and colleague guidance in the clinical context,
    - Experience in guiding the professional development of others',
4. Personal and professional expectations of responsibility for and towards others, and
5. Organisational context of practice.

5.8 Alternative agendas contributing to decision-making

The third focus group was used to re-examine some of the emergent themes and to revisit some of the examples of practice discussed in the first and second focus groups. One of the group members who had been unable to be present at the second group meeting had had an opportunity to read the transcript of the discussion and wanted to probe and challenge some of the ideas that had been apparent in the transcript. This centred on the perception of client autonomy and empowerment as she perceived it had been described. The incident discussed had involved a female client's non-attendance at a family planning clinic held by the Practice Nurse at a GP surgery. The PN had recounted how a client who was on a regime of injections which involved attendance at the clinic every three months had failed to turn up for her appointment.

In family planning for example, I think this is a very skilled role and not a terribly serious thing but potentially it is in that it can result in a problem. About 18 months ago, I decided that I wasn't going to recall everybody but to give them a date on a card, But then there is the point at which you decide since I felt that we were taking all the responsibility away from the person, and of course, if I sent them a letter or if the letter didn't get to them they can blame me
Respondent S

That has just happened at the practice where I work. We decided that we would not send out leaflets a bit like you with the date. You say no you have been given the date. You know you could be at risk and so should be using condoms anyway if you are having various partners etc and they like you have handed that back
Respondent B

I haven't taken it that far so because I still go through the list and see that people haven't missed it so if they go 12 weeks and haven't come up because you know, you could have a problem about saying no its your fault. I think we cann't take quite such a strong line because I see the situation where they might come in 6 weeks later wanting a TOP (termination of pregnancy) so you know then I think well which is better for me to do that injection
Respondent S

Do you find that quite a lot of people do come themselves though?
moderator

I just had two this afternoon who hadn't come last week and so I rang both of them. The first one was terribly apologetic and she usually does make an appointment. The other one last time she was too late and we had to do an emergency contraceptive. Because you know we do have very strict protocols and so this time I could see the same thing happening again and so I rang her and she says she will remember next time so she is trying to remember.
Respondent S

But surely people have the depo because they cannot remember to take the pill?
Respondent B

But some people say, oh! well they cann't take responsibility for themselves and so you have to do it for them and now I think that if you take it completely away from them then you don't teach anybody anything. So people have to be given it. But there are some people like your case it is only

> so far you can go and you know that they cann't take on any more responsibility and it is not fair for them to do so.
> *Respondent S*

Here respondent S is explaining that she telephoned the client to remind her to attend for a family planning consultation. This had arisen as a result of several factors. These include, her knowledge of the effects of non-medication resulting in a pregnancy; her relationship with the client and a sense that she was attempting to move the client to a position of empowerment. This latter aspect was a cause of conflict given the impact of unwanted pregnancy, on the client's life experience. This may also be related to views on abortion as well as the effects of hospitalization on family life. Other factors that influenced the equation were that the PN holds the client's records and therefore had access to the information required and had also sought permission on a previous occasion to telephone the client, should an occasion warrant this. In addition, she was attempting to address a prior system, which had been in place in which the previous PN had always sent out reminders to clients.

The CPN had read the account of the intervention. She found herself feeling very distressed and even angry that in her opinion, this action had undermined the client's autonomy and any move towards enabling her to take responsibility for her own actions. She sees it as the nurse relating to her own needs rather than the client's needs as the following extract shows:

> I find that quite difficult because my job, as I see it, is to actually promote independence but I would see that as co-dependence and yes, we would write once if somebody was really ill. But sadly we talk about it or we ring them up but we don't go round and drag them round. We wait until a crisis happens and they come back into the services again. It is distressing but for our client group we don't keep going out all the time because it would make me feel better. I feel exactly like you do sometimes. I think I wonder how he is but

> again and think hang on girl get your professional head on. I am not the mother I am not the father this is a grown adult and the law gives you rights. And I think it an infringement of civil liberties.
> *Respondent A*

She went on to explain that given the nature of her work within an acute mental health assessment team in the community, she has to actively encourage clients to engage in their own care. This can result in her taking a high level of risk in facilitating clients' engagement with his/her care and treatment needs. She perceived the action taken in telephoning a client, to be ultimately dis-empowering and suggested that unless clients are exposed to the consequences of their own actions, they are unlikely to take responsibility for themselves.

Wilmot (1995) illustrates this type of disparity in perception of care needs with reference to DN and Social Worker's (SW's) differences in constructing care decisions. Using Habemas' (1991) analytical framework of ideal speech conditions, he argues that alternative agendas and expectations of the care environment arise from the socialization processes that influence members of these professions career trajectories. In the example described above, the debate was heated and raised several pertinent issues about the nature of client autonomy and responsibility. As the narrative unfolded, it was evident that the Community Nurses were interpreting the event on a range of levels.

The PN was aware that:

- She had a range of knowledge and experience the types of treatment available and of the consequences of non-medication to clients in similar circumstances,
- She had knowledge of the circumstances of the individual and the impact failure to seek treatment may have on her particular situation,

- She had a relationship with the client over a long period of time which suggested that such a communication would not be intrusive,
- As the nurse conducting the clinic, she had the autonomy to act in this way,
- As a practitioner, she had inherited a system of working in which the responsibility for reminders had rested with the nurse and although she had put systems in place to address this in keeping with the philosophy of working in partnership there were vestiges of the former system within her work context, and
- She was aware of policy statements and the philosophy of encouraging client independence and autonomy. In this situation, she saw this reminder as a prompt to encourage the client to take responsibility.

The CPN in contrast works within a different set of opportunities and constraints. Her perception was that in her area of work, she has to take very high levels of risk in promoting client independence. Although she may have a 'working knowledge' of a client population in a geographical 'patch' she would be unlikely to follow a former client up without a direct request or referral for contact. The acceptance of the referral would also depend on the review and acceptance by the Mental Health Team (MHT). Although a member of the health or social care team, or even a neighbour of a former client may suggest that they may be in need of intervention the acceptance and allocation of clients is a MHT decision. This involves members of the team including the psychiatrists, SW's and CPNs discussing the case and considering the appropriateness of the referral and the possible alternative sources of support. Following acceptance of the case the ongoing care becomes the nurse's responsibility, if the case is allocated to him/her, for the assessment and intervention. However, the review of the effectiveness of

the care programme continues to be a team responsibility and subject to regular team review.

This discussion centred on several themes:

- On the propensity to take risk,
- The nature of the dilemma in situ,
- The consequences for the client and family,
- The nature and perception of the service being offered and the differences between an ongoing client base in GP practice and an acute assessment and intervention mental health care context,
- The way in which resources are allocated and managed within the service,
- The way in which referral takes place,
- The way in which the practitioner relates to other members of the team, and
- The wider perception of the nature and purpose of health care provision together with societal perceptions of client groups.

Within the text, Layder's (1994) levels of social activity levels are reflected both in the narrative of the event and in the challenge to efficacy of the decision. Within the context one sees the differences between notions of 'mental health' and 'adult nursing' mirrored in the potentially competing constructs of the nurses' responsibility and relationship with clients. Williams (2000) reflects these distinctions in her review of the history of ideas constituting Western medicine when she refers to the distinction between mind and body evidenced in the constructs of 'mental health nursing' and 'nursing'.

Further examination of the text leads us into potentially competing perceptions of responsibility and client autonomy. The notion conveyed reflects a sense of political individualism. This places the emphasis on personal responsibility, which according to Williams (2000) relies on personal, moral responsibility for individual prosperity and self-actualisation. What transpires in the text, however, is a modification of the concept, which may be a result of the dynamics of culture. This would account for the differences in the interpretation of values and beliefs evidenced within the care setting.

According to Layder (1994), this dynamic results from differences in the personal trajectory of the individual. This includes the self, the situated activity of practice, the setting reflecting the discipline or branch of practice work and the context that informs our beliefs about health care and the nature of responsibility. These impinge on the way in which practitioners from different disciplines interpret and act on the presenting issues.

5.9 Alternative constructs of autonomy

What we see emerging are contrasting expectations of Community Nursing practice and client autonomy. The PN within the context of family planning is working with a client group with whom she has a sustained relationship over a long period of time who are able to make informed decisions. Her clients come from the practice population and as such comprise the client group and can self refer. The PN works according to practice protocols in administering medicines, drawn up by the doctors and practice nurse team. It is assumed that within these parameters the nurse has responsibility for her decision-making in client care. This contrasts with the CPN's context. She works with a high-risk group of people within a service, which receives limited finance often targeted at certain types of intervention. The position is further complicated by society's view of the client

group. The decision-making process for acceptance and monitoring the client's welfare has evolved as one of assessing the client's propensity to follow a care plan and the responsibility for accepting and monitoring the referral becomes a MHT responsibility.

The ethical principle of autonomy appeared to be the key theme here. However, whilst both Community Nurses apparently prioritise the client's needs, the respondents demonstrate a different emphasis dependent on their contextual and discipline frames of reference. These include the nurses' own perspective of her role, the relationship with the client and with other professional groups, the setting in which the interaction takes place and the wider societal perceptions of the client group and the care intervention itself.

Figure 7 overleaf derived from Layder's (1994) research map, illustrates some of the layers of difference affecting the interpretation of this event.

Figure 7 Theorizing differences between Practice Nursing and Community Psychiatric Nurse perception of incident

		Practice Nursing	Community Psychiatric Nursing
↑ History	CONTEXT	**Macro social forms organisation** Values informing health: physical aspects and reproduction and abortion, NHS and public perception of Nursing , Practice nurses originally 'handmaiden' of GP, Predominantly female nurses.	**Macro social forms organisation** Values informing mental health and psychiatric services Public perception of mental illness as deviant behaviour Public perception of Mental Health services seen as custodians constraining deviant behaviour Large proportion of MH and CPN nurses male
	SETTING	**Intermediate Social Organisation** NHS and GP Service, Service provision in locality, Client discretion as to which GP registered with	**Intermediate Social Organisation** NHS and Mental health services, Services within mental health services area, large geographical area, Referral via GP services.
	Situated activity	**Social Activity** Self referral following initial consultation with GP as client on GP practice case is not closed, Face to face activity of nurse and client, Issues of power, empowerment assumptions clients are 'well' and can come forward for treatment, Relationship of public and private spheres, In GP premises, Access to documents, telephone etc., Expectations of team member nurse is autonomous within protocols.	**Social Activity** Client referral through other , allocated by team discussion, Client enters into a contractual agreement and is discharged on completion of care. This is dependent on interaction nurse and client and team discussion Issues of power and empowerment high on agenda because of need for client to be able to live independently without professional intervention, Issues of risk both for client and public given high profile media interest when things go awry, which tempers agendas for empowerment etc.
↓	Self	**Self identity and individuals social experience** Education in Adult Nursing focus on disease intervention and one to one nurse to client responsibility, Transfer into Practice Nursing, Perception of responsibility to the client, Personal beliefs.	**Self identity and individuals social experience** Education in Mental Health Nursing and CPN focuses on mental health issues and communication skills. Community nursing usually an extension of initial skills, Tend to have team approach to decision-making, Perception of responsibility to the client and carers, Personal beliefs.

Illustration of some aspects of differences in between PN and CPN levels of social activity following Layder (1994)1994

The differences reflected in the table appear to impact on the two respondent's interpretation and actions regarding client autonomy and empowerment. These interpretations were influenced by a range of factors and were not simply the result of the direct encounter.

For example, the PN is seen to be working with a 'well' population in terms of family planning advice. However, her former colleague, whom she has replaced, had set up a system which reflected a paternalistic attitude to care, illustrated in the system of sending reminders for appointments. The respondent is attempting to establish a more equal relationship with the client, however, she is constrained by the historical development of the practice setting.

In contrast, the CPN works with clients who are often stereotyped as deviant and 'other' in society. As Davies (1998) reports only about 10% of people with mental health problems are referred for mental health services since GP's have perceived that they are well able to cope with people with conditions such as depression. This tendency to refer clients with profound problems serves to compound the perception of people receiving treatment from mental health services as 'mad'. In addition, although for more than thirty years there have been attempts to encourage CPN's to be based with GP's this is still not the case. The respondent in this study is based in an acute mental health unit. This physical distancing may also contribute to the nature of the referral relationship.

The notion of containment is also reflected in the number of male recruits to Mental Health Nursing. Unlike in Adult Nursing where 90% of recruits continue to be women, more than 50% are men in Mental Health nursing. This gender differential

may also contribute to the development of different constructs of the nature of nursing work (Davies, 1995).

In addition, although CPNs anticipate working in collaboration with social services there have been concerns that they have been seen as providing an ancillary service rather than as equal partners (Davies, 1998). This dynamic may result in the CPNs attempting to reassert their professional roles including in preventive work and counselling. However, various government initiatives, such as reflected in the media interest about containing psychotic people mitigate against this and the sense of the custodian re-emerges (Symonds and Kelly, 1998).

The discourse suggests that a range of factors shape the respondent's constructs of autonomy. The PN engages with a culture reflecting vestiges of paternalism. She is therefore, grappling with agendas of empowerment in a culture that has not traditionally subscribed to this philosophy. The CPN whilst articulating a commitment to enhancing client responsibility and autonomy works within a climate in which societal views and policy agendas mitigate against encouraging such an approach. This extract from Respondent A illustrates these tensions:

> Mental health is always in the doghouse in that sense. In a recent article in the Evening Post MR X the coroner actually made comment there was a patient at Y hospital who had been admitted and diagnosed, a treatment plan offered and whatever they could and he had a contract because he was known to be a drug addict, I think he was mainlining I am not quite sure, and they had a contract on the ward that if he came back if hc had gone on a visit and he came back and had taken anything ... they did a screen for it and he had had to agree to this ... everybody got together and said yes he had been using drugs there is nothing we can do for him. We are going to discharge him.
> He was discharged and he came out and he killed himself. What it was he was an alcoholic, and that is not decrying alcoholism, what it's saying is that there was another component to his health care. There was nothing you could do. He was offered drugs and treatment in an appropriate place. He was offered drugs to help withdrawal from alcohol.

> Mr X felt that they (hospital Y) were at fault because after discharge they had not followed him up and this constituted that Y hospital had a sense of negligence about it that we were in that there was no evidence of follow up. But I thought what are you going to do? The parents were angry that he hadn't had the care, but we had done everything, as members of the WWT (*term anonymised*) everything that you could. And Mr X let the side down in a sense by saying it was contributory it was negligence What do you do if somebody won't accept. He is free to do what he likes in law it is not a criminal offence so if a grown adult chooses to take his own life to abuse drugs to an extent that you can kill yourself, although it is very sad at the same time.
> *Respondent A*

In the respondent's view, the MHT have done everything that they can to improve the clients health. However, he has not complied with his treatment regime. Within the policy of the organisation they have as they perceive it managed care in a way intended to promote the client's autonomy. However, the onus was on the client to comply with the agreement. Other stakeholders however construe the series of events differently. Whilst the MHT attempt to promote independence others seem to be suggesting that they should have protected the individual. This assumes an emphasis on preventing harm in contrast to promoting independence. The MHT, therefore have a dilemma in attempting to promote stated agendas in empowerment and shifting responsibility to the client within an external context which perceives their role as custodial and as protectors from harm. This extract reflects the ethical choice encountered in practice between emphasising autonomy or care referred to by Gilligan (1982) and Noddings (1984) discussed in chapter two.

In terms of the individuals construct of autonomy the two respondents have an apparently similar agenda in attempting to promote client independence but both experience limitations as a result of societal views, government policy and the culture of their professional and organisational contexts.

5.10 Legitimacy of difference: Reciprocity and Integrity

In exploring the ethical stance of the respondents, they were comfortable that they do not view the nurse-client interaction in the same way. There was a sense of the legitimacy of difference both between different disciplines and indeed within different client encounters. Although the respondents were willing to hear about other perspectives and consider the implications of other points of view this did not destable their own world-view. This appreciation of the other has a resonance with Young's (1997) concept of an asymmetrical reciprocity in relation to moral respect. She argues that whilst respecting diversity and particularity that it is neither possible nor necessary for the individual to adopt the other's standpoint. Young (1997) argues that people:

> meet across distances of time and space and can touch, share and overlap their interests. But each brings to the relationship a history and structured positioning that makes them different from one another, with their own shape, trajectory and configuration of forces.
>
> *Thus the*
>
> ethical relation is structured not by a willingness to reverse positions with others, but by respectful distancing and approach toward them.
>
> (Young, 1997:151)

This sense of asymmetry in reciprocity is evidenced in the discussion of the client situation. With respect to decision-making, the respondents indicated that acknowledgement of the difference in appreciation of a care situation also meant that within a client-nurse situation they would attempt to enable the client to develop the skills required to carry out care 'safely'. However, they also acknowledged that this construct has a range of meanings dependent on context.

Respondent J's example with respect to intravenous infusions (IV's) intimated that the nature of a problem and the ensuing decision regarding a client situation has a temporal aspect. In a situation in which complex technical care is to be administered by carers in the home, an initial assessment may indicate that this is not possible. However, by putting in place a learning package to enable the client and carer to understand the complexity of the task and the responsibility involved this may be addressed.

What we see emerging here is a commitment to the notion of client autonomy in the sense of the ability and opportunity to make an informed choice. The underlying principle of maintaining the safety of the client and working within the duties and obligations inferred from the organisational context may however over ride the client's stated wishes. In parallel, we also see the commitment of the nurse to helping the client to learn about their care in order to enhance their potential to undertake the care.

We also see emerging an alternative construct of integrity in which the relationship that the nurse has with the client and carers is as significant as professional expertise and knowledge. The nurse is expected to be able to balance a range of stakeholder interests whilst working with clients to optimize their care options. This reflects a relational aspect to integrity in which the nurse shares her expert knowledge with the client and also respects his/her perspective.

This example illustrates that a complex matrix of issues affecting the perception of ethical principles. Different aspects and perceptions have a higher profile dependant on stakeholder interests and the stages of development of the situation.

5.11 Use of language

The respondents did not use terminology found in the ethical literature in their analysis of their concerns. However, several ethical concepts, such as autonomy and integrity and responsibility to and for a range of stakeholders were, implied in the text. It was apparent that the respondents do use different forms of language when talking about technical aspects of care. For example, they would refer to IV's (Intravenous Injections) or specific legislation affecting care but they do not refer to terms, such as beneficence or fidelity although ideas, which reflect these concepts, are evident in the text.

It is not clear from the focus group discussions whether the respondents change their language register when discussing issues with other professional groups. The contrast in the use of other specialist language does however suggest that ethical language is not part of the everyday language of nurses. However, is this because of the complexity of the environment in which the practitioners work or is it because they do not have the same facility with the language? What is evident is that, when pressed to do so within the focus group discussions, the community nurses could very clearly express their concerns and defend their particular perspective on care. The discussion with respect to client autonomy reviewed earlier illustrates this.

However, why do I have a concern with the nature of the language used to express the ethical dilemmas experienced in the care environment? Why have I expressed an expectation that such language *should* be present? Indeed does familiarity with another type of language enhance the opportunity for discussion or can it impede it? Is it the language that is the important aspect of the dialogue or is facility to explore complex concepts the key issue? Had I become bounded by an expectation that the formal language and discourse of ethics best served the purpose of these clinicians?

Lester's (1998) models of learning and practice may inform this dilemma with reference to the tensions between the expectations of academia and practitioners with respect to learning in the workplace. His diagram illustrating this tension is shown below.

Figure 8: **Two paradigms for learning and practice**

	Model A	Model B
Character	Technical, logical, convergent	Creative, interpretative, divergent
Focus	Specific: primarily economic performance and societal stability; measurable outcomes	Holistic: dynamic personal and global wellbeing, valuable outcomes
People	As citizens, role occupants, human resources	As unique individuals, agents, origins
Work focus	Primarily employment	Socially and economically valuable activity, including in 'hidden' economy
Capability	Solvable, convergent problems	Congruent futures; 'messes', problematic situations, divergent problems
Approach	Solving problems; applying knowledge competently and rationally	Understanding problematic situations and resolving conflicts of value; framing and creating desired outcomes
Criteria	Logic, efficiency, planned outcomes; cause-effect, proof	Values, ethics, congruence of both methods and outcomes; systemic interrelationships, theory, faith
Epistemology	Knowledge is stable and general; precedes and guides action	Knowledge is transient, situational, personal and unique; both informs action and is generated by it
Validation	By reference to others' expectations: standards, accepted wisdom, established discourse; 'truth'	By questioning fitness for purpose, fitness of purpose and systemic validity; 'value'
Thinking	Primarily deductive / analytical; sceptical of intuition	Inductive, deductive and adductive; uses 'intelligent intuition'
Profession	A bounded, externally-defined role, characterised by norms, values and a knowledge-base common to the profession	A portfolio of learningful activity individual to the practitioner, integrated by personal identity, perspectives, values and capabilities
Professionalism	Objectivity, rules, codes of practice	Exploration of own and others' values, personal ethics, mutual enquiry, shared expectations
Professional standards	Defined by the employer, professional body or other external agency according to its norms and values	Negotiated by the participants and other stakeholders in the practice situation in accordance with their values, beliefs and desired outcomes
Professional development	Initial development concerned with acquiring knowledge, developing competence and enculturation into the profession's value system; continuing development concerned with maintaining competence and updating knowledge	Ongoing learning and practice through reflective practice, critical enquiry and creative synthesis and action; continual questioning and refinement of personal knowledge, understanding, practice, values and beliefs

Acknowledgements to Schön (1983) and Fish (1995)

These models have parallels with Davies' (1994) analysis of cultural codes of gender discussed in chapter two. Her contrast between masculine professionalism as

promoting responsibility to self, abstract rule governed thinking and skills as portable acquisitions contrasts with the feminine notion of connectedness, responsibility to others, emphasis on experience and loyal to principles and reflective. The masculine typology seems to assume a form of knowlcdge that is possible to master and become in 'control' of which has parallels with Lester's model of learning which reflects his perception of academic institutions conduct of assessment.

Lester's (1998) diagram suggests that the current world of practice is dynamic and uncertain. It requires the practitioner to be flexible and continually questioning their ways of learning about their work. The emphasis shifts from the practitioner as expert, to one that requires him/her to demonstrate flexibility, adaptability and a range of expertise.

Expectations of codified knowledge, external standards and codes of conduct do not bind the practitioner. He or she is required to critically evaluate all aspects of his/her role within a fluid expectation of diverse forms of knowledge. This perception of practice is similar to the feminine construct of professionalism described by Davies (1995).

Lester (1998) argues that adherence to an expectation of the 'expert' rather than 'expertise' can inhibit the higher order learning required to work in situations of dynamic complexity. Was my concern with the absence of the language of ethics therefore, a misnomer since the crucial aspect is the facility to express the complexity of the care environment and explore the dynamics of the situation? By perceiving an absence of 'formal ethical language', was I subscribing to a perception of knowledge as codified and abstract rather than as diverse and flexible?

The literature would suggest that currently nursing curricula do not address the complex dilemmas encountered by Community Nurses. As Seedhouse (1998, 2000) asserts, ethics do not constitute a core component of health care curricula. Although bio-medical ethics are discussed, within the context of technological advances, changes in working practices informed by a range of value positions are not explicitly addressed. For example, health promotion activities are not ethically neutral and team approaches to care give rise to concerns about priorities for practice and contractual duties. The dilemmas of responsibility and ethical positioning are therefore complex. The text in this study suggests that the Community Nurses are aware of these dilemmas and are willing to engage in discussion about them. However, since they did not use ethical discourse within the focus groups, one has to uncover the principles in the text.

Gastrell and Coles (1996) assert, the UKCC expects that 'Community Nurses will practice ethically and legally alongside other professionals' (1996:185). What is not clear from this study is whether the language used reflects the context of the discussion in the focus group. It is not possible to ascertain if the respondents use different language in another setting. If the language used does reflect that used in encounters with other professional groups does this affect the outcome of care decisions? Alternatively, are Community Nurses able to comprehensively address ethical issues with reference to a client orientated language register?

5.12 Summary of key points

This chapter has reviewed the dialogue with the respondents and has suggested that the following issues have emerged as key themes.

1. There are differing perspectives on assessment and self-assessment. The conflicting agendas informing assessment strategies impinge on the respondents' experience resulting in a degree of ambiguity about the purpose of assessment. However, it is clear that complex decision-making in clinical practice requires the practitioner to be able to make an informed judgement about their choices and actions.

2. In situ theorising suggests that risk, confidence and integrity are key aspects of this judgement and that engagement with self-assessment is allied to the support and culture of the professional context.

3. The Community Nurses give careful consideration to the way in which they conduct their practice.

4. The expression of ethical principles does not refer to the language evidenced in the ethical literature.

5. A key concern in all the accounts was the way in which the respondents relate to the stakeholders and balance the interests of the various parties involved. This suggests that there is a relational aspect to their ethical conduct.

6. It was evident when a multi-level critique is applied to raise awareness of the levels of social interaction that the discourse is informed by a range of factors on various levels including the individual, organisational, professional and societal expectations of the interaction.

In chapter six I will review the limitations, implications and recommendations arising from the study.

6 Chapter 6: Limitations, Implications and Recommendations

6.1 Introduction

The aim of this study was to explore how self-assessment affects the way in which Community Nurses conceptualize and employ ethical frameworks in their decision-making processes. This is set against a background of increasing complexity in heath care environments. Within shifting perceptions of professionalism, increasingly complex care delivery in the home and changing relationships with stakeholders to contend with Community Nurses are grappling with ways to understand and articulate their decision-making processes. However, the emphasis on the exploration of bio-medical and unusual events in health care curricula (Seedhouse, 1998, 2000), limits the opportunity to explore the ethical implications of changing practices in health care. This study has therefore sought to examine how Community Nurses conceptualize their ethical frameworks and to explore if self-assessment affects the way in which they engage in operationalising these constructs.

This chapter presents the limitations, implications and recommendations arising from the study.

The limitations of the study are discussed and justified in this chapter. The research methodologies used and the key issues identified as arising from the respondents discourse, are presented together with recommendations for advancing the support of learning using self-assessment with respect to development of ethical decision-making in Community Nursing practice.

6.2 Limitations of the study

According to Rudestam and Newton (2001:90), limitations refer to restrictions in the study over which the researcher has no control. For example, the researcher may be limited to a narrow segment of the population or the research method he/she wishes to use because of external constraints. Arguably, the commitment to a particular research methodology may also affect the conduct of the research. As Neal (1998) demonstrated in her study of Equal Opportunities in the HE sector, her commitment to a feminist approach brought a range methodological concerns. As a feminist researcher, she also met barriers in accessing the research population and in disseminating her results. These factors may present opportunities or conflicts depending on the nature of the concerns and the impact they have on the phases of the research process. The following discussion therefore refers to the constraints of the research situation and the difficulties in sustaining the commitment to a postmodernist approach.

This study was conducted as an inductive inquiry that sought to establish Community Nurses conceptualizations of ethical decision-making. It also explored their perceptions and experiences of self-assessment in order to establish if there are any links between this assessment strategy and the development of ethical decision-making within Community Nursing. The study included a purposeful sample of Community Nurses who are currently in practice. They had all undertaken self-assessment within a module of their CHCN degree programme. The data emerged from the discussions that took place in the sequential focus groups. The findings are therefore specific to this group of people and to the context in which they practice (Guba and Lincoln, 1989).

Undertaking the study within a postmodern framework brought its own dimension to the study. As Rudestam and Newton (2001) observe, researchers committed to postmodernist methodology are perceived as 'critics circling like vultures to pick over the spoils of positivism' (2001:51). Others argue that researchers developing postmodern approaches are trying to carve out new space within academia (Usher et al., 1997). Both of these images result in negative and skeptical impressions of postmodern methodology. However, within this research endeavour postmodernism offered new ways of engaging with the research population. In particular, it charges the researcher with addressing the power dynamics within the research relationship. It also prompted me as the researcher to engage in alternative ways of examining the discourse within the literature and in the emerging data. Whilst some people doubt this approach these dynamics prompted me to critically review both my research stance and the ways in which I conceptualize my field of practice. This allowed for some element of risk which, led to the development of alternative ways of working with established research methods, resulting in the development of the sequential focus groups.

As Coffey et al. (1996) assert the postmodern movement has provoked social researchers to re-evaluate their approach to and representation of research. However as they recount researchers working in more established traditions have also been reviewing their positions. In my experience of engaging with the postmodern approach, I found that it was difficult to review the data effectively without reference to what I perceived to be potentially compatible approaches. For example in emphasizing the respondents' perspectives structural dimensions affecting experience in a less obvious way remain obscured. In deconstructing the respondents' texts I found it impossible to make sense of the dialogue without reference to the wider

context of contemporary health care. This therefore distances me from a purely verbatim account of the dialogue and representation of the respondents' voices. Whilst I still wished to represent their perspectives I found myself looking for other tools which would allow me to examine the texts in other ways which would allow me to maintain the integrity of the project.

In reviewing the texts I initially drew on authors such as Guba and Lincoln (1989, 1994) who sought to include respondents in the design and reporting of research. They had extended their approach to explore with stakeholders their perspectives in reviewing the focus of inquiry. As Schutt (1999) observes this was an attempt to develop an interactive research process with the intention of enabling the researcher to understand the perceptions of the stakeholders hold of the phenomenon under study. The aim is to construct a shared perspective. However, I was hoping to move beyond a shared experience towards a transformative approach to research. I wanted not only to share the respondents' perspective but also in some way to engage with them in influencing the world of practice. As Alvesson and Scoldberg (2000) assert, in engaging in research in this way representation and presentation become critical methodological concerns.

One of the difficulties I have encountered however, results from my socialization within the positivist tradition evidenced in health care. The respondents have also experienced a similar socialization process. This has brought with it difficulties in grappling with the relatively unstructured and apparently nebulous approach postulated in postmodernism. Gallagher (1995), shares similar concerns in reporting her experience as a doctoral student engaging with approaches within qualitative research. Having come from a scientific background, she had similar concerns and began to question the nature of the research enterprise. As Gallagher (1995) observes,

Guba and Lincoln's (1989, 1994) text whilst advocating interaction with their respondents also subscribes to seeking objectivity in the research process. She reminds us that this striving for objectivity is at odds with seeking meaning within discourse.

I found myself attempting to find ways to overcome my uncertainty in ways that would not undermine the trustworthyness of the research. I was sure that meaning and in some way of re-conceptualizing this would be best realized by dialogue and confirmation with the respondents. To this end the focus groups developed as a sequential triad in order to engage the respondents in the development of ideas. This enabled authentication and confirmation of the representation of the dialogue. It also resulted in clarification and challenge and contributed to the development of ideas within the group.

Whilst the use of NUD*IST and Layder's research map took the research away from a postmodernist approach, this development enabled me to raise further questions about why the respondents presented issues in the ways in which they did. For example it enabled me to question the socialisation processes of the respondents in order to appreciate why mental health nurses and practice nurses hold different perspectives on client autonomy. This may compromise the postmodernist approach that requires one to foreground the respondents' perspective, however, I found difficulty in raising issues that may indirectly impact on experience if it is outside the direct experience of the individual. I found it impossible to maintain my original position once I began analysing the data. Sustaining such a position may be possible when analysing documentary evidence since it may be possible to engage in a discrete exercise of text deconstruction. Alternatively, action research that immerses every one involved in the research process, may allow all players to have an equal voice in presenting the text.

The aim of the study was to explore Community Nurses' perceptions and experience of ethical decision-making. It also sought to explore the implications this has for self-assessment. However, the exploratory nature of the study does not lend itself to a critical evaluation of these skills in situ. The model nevertheless allowed for the refinement of the focus of the study. The emerging data led to an appreciation of the requirement of Community Nurses to self-assess in practice. This lead to a change in emphasis in the research question. The justification of such development together with the commitment of accurately representing the respondents' texts and meanings also resulted in the presentation of the thesis becoming a key concern. This may be perceived as a further limitation since the genre of the presentation may then deviate from the traditional style of research reports. A particular concern in this study was in balancing the review of the research process without compromising the research results. This is a particular concern given that in my perception the project was conducted in an environment which privileges a positivist tradition that expects clear justification of results rather than deliberations about process.

The pragmatics of time and resources in conducting the study were also an issue. The responsibility lay in ensuring that the methods employed to collect the necessary data were not only appropriate, but also manageable. The development of the sequential focus groups enabled supportive challenge between the respondents and me within a defined period. The culture that evolved also allowed for power dynamics within the research relationship to be discussed and addressed as far as possible. This allowed for the ideas and themes emerging from the data to be probed and extended. It was also possible to authenticate the respondents' meaning. However, given that this was a very small study the extent to which these themes may relate to a wider context are limited.

Despite the limitations of a small study, it does offer some illumination of the subjective world of the Community Nurses who participated in the focus groups. Within the postmodernist paradigm claims for 'truth' and 'overarching' meta-analysis are inappropriate, generalisability is not therefore, a claim made here. However, the respondents dialogue does confirm some trends emerging from the literature. Hopefully, the study will prompt further exploration of the nature and experience of ethical decision-making within Community Nursing and contribute to debates about the development of curricula in this field.

6.3 Key issues and recommendations

The respondents' dialogue illustrates some significant issues about the nature of ethical decision-making in Community Nursing practice, which have implications for both policy makers and educationalists. The study demonstrates that the respondents' experience of ethical decision-making in community practice reflects the complexity of health care delivery in contemporary society. It suggests that Community Nurses need to develop their awareness and skills in analysing ethical frameworks if they are to clearly articulate their rationale for their decisions within an arena in which a myriad of stakeholders hold them to account. As changes occur in organisational cultures, nurses may need to become aware of the agendas influencing these and consider how the resulting changes in ethical perspective will affect their practice. For example, this may allow them to consider how working in an empowering way with clients shifts the power dynamic within the professional/client relationship and how this affects their ethical standpoint. The study suggests that these issues require a high level of skills in critical thinking and analysis. The educational environment can offer opportunities to extend these. The respondents suggest that self-assessment encourages emotional engagement in the learning process. It is also apparent that in

critically reviewing their decision-making in situ the respondents engage in justifying their decisions in a way that suggests that self-assessment is a requirement of this. Self–assessment would appear to contribute to the development of a critical review of ethical processes. However, in exploring ethical issues the respondents did not use discourse found in the ethical literature.

This section begins by reporting issues arising from the respondents and the literature review, with respect to the implications for the development of self-assessment initiatives. It then identifies the issues that may affect curriculum design within the sphere of ethical decision-making in Community Nursing. The significant issues identified and recommendations for addressing self-assessment agendas that are related to improving the process and quality of ethical decision-making are as follows.

1. The respondents perceived that a range of potentially competing agendas impinge on the assessment of Community Nursing practice. At present conflicting messages are implied. For example, assessment agendas being promoted as measures of achievement in contrast to assessment to inform learning. Largely, self-assessment equates with the latter agenda within the education sector. In a climate of continuous change, clinicians are required to continually review their skills and competencies and self-assessment has been promoted in some sectors as a means of achieving this review. By implication, self-assessment is perceived as contributing to a formal assessment of the substantive skills of the individual rather than as informing their development needs. Within the practice arena, the respondents see these self-assessment initiatives as related to the development of agendas in personal accountability resulting in increased individual culpability. As such, there is a perceived conflict in articulating weaknesses in the public domain.

This view is in stark contrast with a model in which self-assessment was perceived as a positive development in which support networks encourage personal growth.

2. The confusion in perceptions of self-assessment agendas suggest that in order to initiate and effectively implement such strategies curriculum developers need to clearly articulate the rationale informing this choice of assessment strategy. Failure to do so results in confusion since there may be very different experiences of self-assessment. In the respondents' view this potentially undermines the implementation of such initiatives.

3. The literature suggests that self-assessment initiatives within the HE sector imply a commitment to a philosophy derived from humanistic traditions. These center on the development of self as a discrete entity. The experiences described by the respondents in this study suggest that this view is too simplistic for the model of self-assessment developed in the WWP module and that required in practice. Their illustrations suggest that the engagement with self-assessment evolves from a range of interrelationships with others including their professional peers. The nature of these relationships appears to mediate the individual's sense of self.

4. The postmodernist literature suggests that we may present with a range of identities dependent on context and agenda. This may result in the fracturing of identity and subsequently in a decline in moral responsibility (Mason, 2001). Community Nursing requires nurses to work with people who are vulnerable in some way therefore educational programmes need to find some way of addressing this decline. The respondents in this study comment that self-assessment can require emotional engagement with the learning process, if developed within a

supportive and challenging environment. This emotional engagement may enhance the student's sense of moral responsibility. In order to foster moral responsibility therefore the curriculum needs to engage the student in the learning process and self-assessment may be one means of achicving this.

5. In the respondents' view the development of self-assessment initiatives depend on the commitment and positive affirmation of students' deliberations both by peers and academics. It would follow therefore that in designing and implementing such initiatives care needs to be taken in considering the following questions:

- Why is the initiative is being recommended?
- How it will be achieved. For example,
  - What model is to be adopted?
  - How will support be afforded the students?
  - What implications are there for supporting it?
- Who will be identified to support it?
- How will academics and students be briefed and developed to support the assessment strategy,
- How students will be supported in undertaking self-assessment?

6. The respondents demonstrated that engaging in complex decision-making requires them to continually critically review their performances. The processes they demonstrate suggests that this requires them to judge their knowledge and skills and to consider alternative courses of action. The respondents argue that this

process goes beyond their experience of reflection and that the important issue is in engaging in the judgement of themselves.

7. In order to enhance the process of developing critical judgement educational programmes need to develop a culture in which students are encouraged to engage in critical review of their own self-development. Some of the respondents suggest that developing self-assessment initiatives that encourage supportive challenge within peer groups can enhance this process.

8. The decision-making taking place in Community Nursing settings involves the Community Nurse in balancing a range of stakeholder interests. It also involves actively working with others in order to optimize client care. For example, in enabling a client to be cared for in the home, the Community Nurse must engage in assessing the context, and work with carers to enable them to develop the skills and knowledge to provide care competently. Failure to carry out a comprehensive assessment and develop an adequate care package may result in the individual being called to account. This may be in their own right or as a member of a team. Although it is usually assumed that this will be by the professional body the respondents accounts suggest that this may also be any interested party, such as the client, carer, the media or other professional.

9. The nature of professionalism is changing in contemporary health service agendas. Respondents indicated that policy agendas are resulting in a number of changes in professional relationships and organisational culture requiring them as nurses to engage in new systems of working which address power differentials within their working relationships. These include:

- Public heath initiatives, which require a consideration of population needs as well as those of individual clients.
- Partnership working in which clients, carers, the voluntary sector and professionals work together in providing care packages.
- Enabling clients and carers to feel adequately prepared to deliver complex care in the home which may imply empowerment of individuals and communities.
- Interprofessional working which implies sharing of responsibility for care and requires negotiating with other professional groups in identifying care agendas.
- Increased accountability and culpability reflected in clinical governance and performance indicator agendas which requires clear articulation of nursing agendas.

These agendas require Community Nurses to critically evaluate their working practices and to consider alternative ways of conceptualising the nature of care delivery. By implication this includes reviewing the value base informing nursing practice and the implications for ethical decision-making. In order to achieve effective working relationships the evidence would suggest that Community Nurses have to develop ways of openly sharing these agendas with others. Self-assessment seems to be a crucial aspect of the clinician's repertoire of skills which enables them to engage in critical review of their decision-making and enable them to communicate these deliberations to others.

10. In addressing the issues that arise from stakeholder interests the respondents have to balance a range of ethical concerns. However, the discourse used to describe these concerns suggests that terminology derived from the genre of ethical theory is not incorporated into the practitioners vocabulary. This is evidenced in marked

contrast to other forms of discourse related to technical aspects of care that the respondents regularly use. It is unclear if this use of language impeded the analysis of ethical dilemmas. However it is evident from the literature review that low priority is given to ethics in health care curricula (Seedhouse, 1998, 2000). Ethical principles inform all aspects of care, in contemporary contexts informing health care these need to be articulated to a range of stakeholder. Community Nurses therefore need support in developing the skills required to enhance their articulation of their concerns and decision-making processes. In order to address this issue Community Nursing curricula need to develop aspects of ethical theory and application within the programme of study to enable the Community Nurse to actively engage with the principles that inform their practice.

11. The ways in which the respondents describe their relationships with clients and professionals suggests that there is a relational aspect to their decision-making. There is an emphasis on balancing the interests of the client, carers and colleagues within a context influenced both by organisational culture and wider societal values that inform the health care environment. In negotiating these interests the respondents articulate a relational aspect to their ethical decision-making.

This relational aspect to decision-making in situ suggests that the frameworks of ethics Community Nurses' work with in practice are complex. However, those traditionally taught in health care curricula, focused on bio-medical issues and unusual events (Seedhouse, 1998) limits the practitioner to a narrow conceptualisation of ethics. If the practitioner is to develop skills to clearly articulate their perspectives then they need to have opportunity within educational

programmes to explore the nature of these deliberations within a wider ethical perspective.

6.4 Summary

This chapter has presented the limitations of the study and recommendations arising from the respondents' dialogue derived from the sequential focus groups presented in chapter five. It has identified the key issues with recommendations for reviewing curriculum design with respect to the development of critical review of ethical decision-making within Community Nursing.

Consistent with the theoretical literature, the study suggests that Community Nurses engage in decision-making within a complex, constantly changing health care environment. The interface with their clients is currently influenced by agendas in empowerment and partnership working. In addition, there is a move to public health agendas shifting the balance of care to addressing population as well as individual needs. This context requires the respondents to review their practices and to justify their decision-making processes to a range of stakeholders. A range of ethical principles informs these agendas. Interestingly, although the respondents gave thoughtful considered accounts of their deliberations in their discussion-making they did not use language found in the ethical literature to explain these. This is in contrast to technical language used and explained with reference to their particular discipline suggesting that they are not as familiar with this language as they are with other specialist discourse. In a complex environment in which they are required to articulate their perspective to others it would seem that they would benefit from further opportunity to explore ethical principles. Future curricula therefore need to consider

how students are encouraged to engage with the complex matrix of ethical principles informing their practice in order to develop their skills in articulating these to others.

7 Chapter: 7 Conclusion

This study has shown that the respondents relate a complex relationship between Community Nurses' processes of ethical decision-making and their use of self-assessment in clinical practice. The study submits that self-assessment is a crucial aspect of the in situ decision-making which informs the judgements these Community Nurses make in respect of their performance in practice. The literature on self-assessment in educational settings supports this finding suggesting that self-assessment contributes to the development of critical thinking skills (Boud, 1995, Cowan, 1998, 1999, Brew, 1999). However, the finding that self-assessment is a crucial aspect of practice is new.

The strength of this study has been in the development of the sequential focus groups. This allowed the respondents to develop a supportive culture in which to share and explore their perspectives (Kruegar, 1994, Morgan, 1998) on self-assessment, decision-making and their use of ethical principles. This approach has allowed for the power dynamics within the research relationship to be acknowledged (Connelly and Clandinin, 1990) within the constraints of time and commitment (Schulz et al., 1997). It has allowed the respondents to articulate their views on self-assessment and to suggest opportunities and threats they have experienced in engaging with it. It provides an insight into the position of self-assessment as integral to the repertoire of skills that enhance the critical review Community Nurses engage in within their world of practice.

The attempt at using a postmodern research methodology has prompted a critical review of my approach to research and an interrogation of my assumptions about

Community Nursing practice and research. However, this experience has also raised questions about the efficacy of committing to an approach that appears to foreground the individual experience at the expense of appreciating evidence from other sources. For example, there is statistical evidence of gender disparity within recruitment to nursing but if this stands outside of the personalized account of those participating in research it does not appear to be a legitimate concern. The emphasis on the personalized 'voice' also makes it difficult to analyse the data since as soon as this process begins another level of interpretation commences which distances the research from the respondents perspective.

The study has also contributed to an understanding of the respondents' operationalization of ethical principles. It demonstrates that the respondents explore a wide range of relational aspects of decision-making. Although the discourse used in the exploration of these issues appears to be constrained by an emphasis on bio-medical ethics and unusual events as described by Seedhouse (1998, 2000) the respondents transcend this to discuss a wide range of complex issues. A review of the literature suggests that a postmodernist framework, which seeks to explore issues of collaborative working and occupational heteronomy (Hargreaves and Goodson, 1996) may contribute further to an exploration of these developments.

Several authors affirm the opportunity self-assessment affords in enabling students to develop critical thinking skills (Boud, 1995, 1999, Brew, 1999). Brew asserts the benefits of enabling students to engage with the assessment process, although she also cautions that in developing this form of assessment it must be clearly located within the context of the goals of the educational experience. If it is not, as the respondents in this study suggest, it is treated with suspicion. If however, the rationale for its use is

clear and students are encouraged to develop a supportive peer learning culture it can be very effective in enhancing a challenging learning environment.

Community Nurses need to justify their practice, this is identified as a core requirement of practice within professional practice (UKCC, 1992a, 1992b, ENB, 1993, 1996b, Peach., 1999)). However, there is a lack of evidence as to if and how this skill is developed and maintained in practice. There is evidence in the data of this study that the respondents spend time critically reviewing their practice, but their comments also suggest that the extent to which they routinely do this is dependent on time and context.

The respondents seemed to suggest that it is unusual to support a colleague in the workplace in developing the skills of self-assessment in the way that they have experienced it. Although initiatives such as Vision for the Future (N.H.S. Executive, 1994), promote the concept of clinical supervision, which requires skills in self-assessment, it has been poorly developed within 'adult' nursing. However, it is more developed in Community Psychiatric Nursing. This would suggest that the cultures within nursing disciplines mediate the development of such initiatives. In addition, Brew (1999) asserts that many HE institutions have organizational structures imbued with concerns about the control of knowledge that inhibit the development of self-assessment strategies. She suggests that tutors and course leaders often introduce self-assessment whilst battling against 'conventional attitudes and the constraints of traditional structures and procedures' (Brew, 1999:168). It is important therefore, to consider the context within which such initiatives are situated.

The study demonstrates that Community Nurses give considered accounts of their decision-making process, however, they do not use language described in the ethical

literature to describe their analysis of situations. This suggests that, as Seedhouse (1998, 2000) purports, nurses are not exposed to ethical discourse. The literature review revealed that bio-medical issues and unusual circumstances are considered to some extent, however, the everyday world of ethics is given low priority in health care curricula. The dialogue evidenced in the focus groups revealed that the Community Nurses engage in complex decision-making in which they have to balance a range of interests including those of the client, carer and other professional groups. However, the discourse used in analysing these issues is not articulated in language that formally identifies the ethical principles that inform the decisions. The respondents felt that some ethical issues such as duties and obligations are integral to their practice and did not feel they had to overtly express these. However, this does not address the absence of other terms, which would describe aspects such as the balance of equity and justice or beneficence and non-maleficence. The principles informing these concepts, are embedded in the text but are not overtly stated. Wilmot (1995) argues that different professional groups hold different perspectives in making decisions about care delivery. Therefore, if they are to achieve meaningful dialogue in an inter-professional arena, Community Nurses need to be equipped with the skills to engage in debate about these principles. However, as discussed in chapter five there is a difficulty in assuming that the language is the central concern. The Community Nurses need the skills to analyse their perspectives and those of others in order to address the power differentials evidenced within inter-professional arenas (Leathard, 1994, Wilmot, 1995, Malin et al., 1999). This study suggests that Community Nurses can clearly articulate their position when pressed to do so. A further question arises however as to whether the formal language of ethics would enhance inhibit this type of debate.

The lack of ethical discourse contrasts with the range of technical language used in the descriptions of particular types of nursing intervention, for example, in the management of intravenous therapy. This suggests that nursing' continues to align itself with the scientific aspects of medicine as Lister (1997) asserts.

Given the complex health care environment in which the emphasis is changing to public health agendas, together with partnership working and inter-professional working the ethical balance is shifting. In addition, flatter organizational structures require more personnel to be equipped with critical thinking skills. As Goodson and Hargreaves (1996) argue, these models of practice lend themselves to an ethical framework in which we will see the emergence of collaborative cultures and occupational heteronomy. This contrasts with the concept of professional autonomy, which implies a sense of the professional as an individual expert. In order to engage with these agendas Community Nurses need to be able to articulate their decision-making processes. Curricula that enhance opportunities to familiarize them with the skills to engage in the analysis of ethical dilemmas are therefore key.

As indicated in chapter one and elsewhere this study was conducted as a dynamic process and as such forms the initial phase of a longer project. The following questions regarding the conduct of future research emerge from this thesis:

1. What constraints or opportunities are there in adopting a postmodernist approach when respondents are involved?
2. Does a postmodern approach enhance or constrain theory development if the emphasis is on personalized voices where evidence such as statistical evidence of gender disparity does not fall within the perception of respondents?

3. Does the postmodern approach enable the researcher to 'step outside' and challenge established traditions in research?

4. Is there a disparity between espoused views of knowledge and expectations of language registers used by professionals and the real world of practice?

In order to then to extend the research and consider how curricula design may address these issues I would propose developing an action research project (Punch, 1998). Action research would require more active and sustained commitment from participants and would address to some extent the problems encountered here in interpreting the texts. This might include involving lecturers and students in a collaborative review of their skills in ethical decision making. This would also involve an exploration of the perceptions of 'professionals' in contrast with their experience of practice. This could for example form a theme within a work based learning environment. The aim of such a study would be to capitalize on the existing skills and frames of reference of the research and practice communities in order to extend our knowledge of how individuals experience ethical dilemmas. This would then inform the debates about the development of ethical aspects of Community Nursing programmes.

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Appendix 1

Working with People (WWP) module handbook

Community Health Care Nursing

UZC 030 H3

WORKING WITH PEOPLE

0.5 MODULE

10 CATs at Level 3

January 2001

Contents

Module team:

Jane Fitzpatrick	Module leader
Eric Broussinne	
Mary Hayward	
Glenys Hook	
Julia Muir	
Lorna Singer	
Sylvia Smith	
Sue Townley	

Aims of the Module:

This module links closely with 0.5 module Organisational Management. Some aspects will therefore be integrated as appropriate, i.e. nature of groups.

The content seeks to further develop students' interactive skills in the context of community nursing. It will provide the knowledge and application of relevant psychological theories. These will be further applied in the specialist practice modules. Further integration will be facilitated during practice and supervised practice (i.e. using Hyland Donaldson psychological skills scales, applying models of counselling intervention - Heron).

Learning Outcomes:

The students' existing skills are anticipated to be diverse; the focus will be more specific to self and clients, building on their existing skills, therefore.

By the end of the module the students will be able to:

- critically examine and analyse the development of human relationships in the context of community care;
- identify their own strengths and weaknesses with a view to further development;
- reflect on their own performance and utilisation of inter-personal skills;
- identify opportunities for teaching and apply appropriate strategies/models of intervention;
- analyse factors which influence behaviour in a variety of contexts, initiate responses and evaluate the outcome.

Content:

Students will be initially involved in an agenda-setting exercise, but the following content is seen as relevant:

Teaching skills
Models of intervention/working with people
Psychological aspects of care delivery
Advocacy and autonomy
Relationships between groups/primary health care teams, etc.
Assertive skills
Leadership
Conflict/communication problems and resolution

Methods of Assessment:

1) A 1,500 word essay exploring the principles of teaching and learning, aspects of communication, intervention techniques and relevant psychological theories in relation to your own development.

Essay title

> **Drawing on your self assessment criteria and the themes of the module critically evaluate your participation in interpersonal processes supporting your discussion from entries in your reflective diary and from the relevant literature.**

The guidelines for presentation of academic work at level three are contained within your faculty handbook.

2) An element of self assessment informed from your self development needs will form 5% of the total mark.

3) This module also links with your clinical practice criteria outlined in your clinical practice handbook.

The hand in date for the essay and self assessment components is 21.5.2001

Assessment Weighting:

95% for written assignment
5% for self assessment component
100% plus PASS/FAIL for practical element against pre-determined criteria.

Please note that although you award yourself 5% of the marks the way in which you integrate aspects of your self development into the essay also contributes to your overall grade.

For example if you achieve 75of a possible 100 in your self assessment and 65 of a possible 100 in your essay the weighting adjusts to

	$\frac{75 \times 5}{100}$	+	$\frac{65 \times 95}{100}$
=	3.75	+	61.75
=	Total 65.5%		

Focus discussion groups

Within this module members of the student group will be expected to work together to develop a supportive environment within their peer group. You will be allocated to groups which have been designed to be multidisciplinary in order to draw on the wealth of experience within the group.

Within this forum students will be expected to take a lead role in the development of the focus group. The educational aims are to develop the students' skills of inter and intra communication skills.

Focus groups are scheduled to take place for one hour following the lead lecture/ discussion.

Students are expected to volunteer to lead one focus group session you may do this in pairs. All members of the group will be expected to take the lead on at least one occasion.

As the leader(s) of the group you will be responsible for focusing the group on the task agreed for the session you have chosen to lead. You will have a remit to encourage members of the group to contribute to the discussion. Your role will be to encourage analysis and debate within this forum.

If the group agrees members who are leading the session may ask for support from a peer in terms of overseeing practical issues such as time keeping etc.

Your schedule of leaders will be presented to the module leader by 12.2.2001

There will be some outline suggestions for activities which may be used to develop the skills of the group members made available to you. These will follow the themes of the module.

Within the focus groups students will be encouraged to develop their skills of self assessment, the criteria for which are outlined below.

A member of the academic staff will be available to you for the first three focus group sessions and at other sessions if you negotiate with them to attend. They have a brief to support the initial development of the group and to provide clarification. You may for example call on them if you have a difficulty with the dynamics of your group. They do not have a remit to take a lead role within the group and would encourage group members to negotiate their own agenda.

Self assessment process.

Rationale for self assessment

All the recruits on to the CHCN BSc. course are First level registered nurses with 120 academic credits at level two. Within the CHCN course they are being prepared to work independently within their professional remit in community settings. As practitioners on completion of the course they require a high level of critical thinking skills and an ability to reflect in action. Within this module the focus is on developing the students communication skills with a view to optimising their knowledge of skills required in assessing and intervening in client care. This includes looking at counselling interventions and the wider context of debates surrounding partnership with clients. Within this context it is appropriate to consider allocating a proportion of the assessment weighting to self or peer assessment. Bandman and Bandman [1995] argue that reasoning, analysing the use of language and the ability to weigh evidence are fundamental to critical thinking. Within curriculum development in nurse education the emphasis is on the preparation of independent, flexible and self motivated practitioners capable of evaluating their own skill and performance [UKCC 1986,1990] By enabling students to engage in the process of self assessment these skills will be enhanced.

Personal development including what Bradshaw describes as 'critical reflection' [1989] is regarded as fundamental to the role of the professional nurse. Brown [1990] argues that self assessment strategies enhance students self awareness. Rawlinson [1990] suggests that this then impacts on the quality of nursing care. Within the context of the CHCN course we are preparing nurses for a professional qualification and as such must take into account the recognised criteria required for practice in the students chosen discipline within this module however it is appropriate to negotiate an element of self assessment in order to develop the students own critical thinking skills in relation to their own practice. Purdy [1997] argues that within nurse education programmes lip service is given to self assessment since professional demands rather than personal development are paramount. However one would argue that within a community nursing context it is vitally important for practitioners to develop their own skills in relation to reflection since often their is no one immediately available to confer with when making care decisions.

references to rationale

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Assessment process

Students will be expected to present a written assignment drawing on abstracts from their reflective diary which must conform to the university assessment guidelines for written submissions (see faculty handbook). In addition they will be asked to negotiate self assessment criteria for skills which they wish to develop pertinent to the themes of the module. Some of these skills may develop within the delivery of the module. In addition students may draw on their experiences in practice for evidence of achievement.
Students will mark themselves out of 100. The weighting for your own grading of the self assessment component is 5%. Please note that they way in which you develop your skills and integrate this development into your assignment also contributes to your grade.

Themes for criteria of self assessment

1. Application of a framework of communication

2. Interpersonal communication skills

3. Dealing with confrontation and conflict

4. Facilitation of groups

Students will be expected to write three criteria derived from the above themes which they would expect to be able to achieve by 14.5. 2001

Your criteria should follow the principle of **S.M.A.R.T.** criteria

Specific
Measurable
Achievable
Realistic
Timely

These criteria will depend on your own context and will be dependent on your reflection on your existing skills.

For example some students may choose to use a critical incident to reflect on a specific skill such as active listening skills and use the module to develop their skills in this area. Others may wish to negotiate with their CPT to develop their skills in specific intervention techniques with their client group. Students may also take opportunities presenting within their focus group to develop their skills.

Examples of criteria:
I will develop my active listening skills during my participation in the focus group. I will demonstrate this by paraphrasing, summarising and reflecting the content of the discussions on at least three occasions. I will also practice these skills with a client. I will ask two peers to provide evidence of my achievement in the group and relate my progress in my clinical area in my reflective diary.

I will negotiate with my Community Practice Teacher to lead the client support group within my clinical area within the next five weeks. I will focus on developing my skills in challenging inappropriate behaviour. I will demonstrate this by responding to cues and intervening in a supportive manner. I will ask my CPT for feedback on my progress. I will also take opportunities presenting in the focus group to consolidate these skills.

These criteria should be shared with your named member of staff who acts as facilitator to your discussion group on 12.2.2001

Within the peer group individuals will identify two peers who will be expected to contribute to the evidence of achievement of the criteria. No member of the group will have more than two peers to provide evidence for.

Students may also give additional evidence of achievement of their criteria from other co- workers for example their Community Practice Teacher.

Students will grade themselves out of 100. They may discuss this grade with their peers and/or a member of staff but will take responsibility for their own grade.

ESSAY GUIDELINES FLOWCHART

My interpersonal skills
(personal, educational, professional)
⇓
Self assessment criteria
(**S.M.A.R.T.** objectives)
⇓

My experiences & reflections within
my focus discussion group
⇓

What interpersonal skills am I developing
& observing in practice?
⇓

Evidence from my reflective journal
(include some journal entries as an appendix to the assignment)
⇓

Written feedback from 2 peers and/or CPT
you must have evidence from two people
⇓

All of the above can contribute to the assignment
⇓

The essay should reflect the content of the module
which includes all of the above

To be able to demonstrate analysis and synthesis, you may focus on one or two interpersonal skills

Remember you must draw upon some psychological theories to inform your answer

Check your faculty guidelines and award route handbook re level three criteria

Working with People Module Programme

session 1 29.1.2001	Introduction to Module; aims and objectives etc. Introduction to the concept of self assessment Models of self awareness Formation of Focus discussion groups	Jane and Eric
session 2 5.2.2001	Introduction to group process Focus discussion groups	Sue
session 3 12.2.2001	Models of Intervention; Egan. Focus discussion groups	Eric and Jane
session 4 19.2.2001	Assignment guidelines; Confirm self assessment criteria; Focus discussion groups	Jane
session 5 26.2.2001	Models of Intervention; Heron Focus discussion groups	Sylvia and Jane
session 6 5.3.2001	Models of Intervention; Transactional Analysis Focus discussion groups (clarify content for negotiated sessions)	Eric
session 7 12.3.2001	Communication Skills Revisit core skills and consider your position in relation to the models of intervention; Focus discussion groups	Jane
session 8 19.3.2001	Power Issues; Group Processes. dynamics and interprofessional relationships. Focus discussion groups	Jane and Eric
session 9 26.3.2001	Power issues Group Processes; Negotiation; Focus discussion groups	Jane
session 10 2.4.2000	Negotiated session Focus discussion groups.	Sue
session 11 30.4.4.2001	Negotiated session Focus discussion groups	Jane and Eric
Bank holiday 7.5.2001		
session 12 14.5.2001	Formalise self assessment statements evaluation of the module	Jane and Eric

Members of the tutor support team for the self assessment process are asked to be available for the second half of the first three sessions and available on request to the groups for follow up sessions in the discussion groups The lecture is at 15.30 to 16.30 and the focus group discussion sessions are scheduled 16.30 to 17.30 hrs.

Student groups

Group A room 1B25
Staff Facilitator Mary Hayward

Group B room 1C02
Staff Facilitator Sue Townley

Group C room 1A04
Staff Facilitator Glenys Hook

Group D room 1C01
Staff Facilitator Sylvia Smtih

Group E room 1F16
Staff Facilitator Lorna Singer

Group F 1G04
Staff Facilitator Julia Muir

Reading list:

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Baron, R. S., Kerr, N. and Millar, N. (1992) **Group Processes, Group Decision, Group Action,** Buckingham: OU Press.

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Leathard, A (1994) **Going Interprofessional: Working Together for Health and Welfare,** London: Sage Publications.

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Vaughn, S. Schumm, J.S. and Sinagub, J. (1996) **Focus Group Interviews in Education and Psychology,** London: Sage Publications.

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Appendix 2

Ethics application to the University of the West of England

University of the West of England
BRISTOL

Faculty of Health and Social Care

Faculty Ethical Sub-Committee

Research project proposal for ethical consideration

Name of Researcher(s) ***Jane Fitzpatrick***

Type/Level/Purpose of Research (BSc, MSc, MPhil, PhD, staff)
Staff member at UWE and student undertaking Doctorate of Education program at the University of Bristol

Supervisor/Advisor/Mentor
Dr. Tim Bond, School of Graduate Education, University of Bristol

Contact Address
Graduate School of Education
University of Bristol
8-10 Berkeley Square
Bristol
BS8 1HH

Telephone Number
0117 928 7167

Title of Project.
An investigation into the effects of exposure to student self- assessment on clinical decision-making in community nursing practice.

Outline of Project
Six to eight respondents will be selected from two previous cohorts of students who have attended the Working with People module in the Community Health Care Nursing Program. This module includes a component of self- assessment, which forms the basis of the academic assessment protocol and informs the student's judgement of their competence in their chosen area of communication skills. These practitioners are either now in full or part-time clinical practice and are involved in making complex clinical decisions. The research would seek to explore if and how educational assessment and in particular self- assessment has informed the practitioners' clinical decision making skills.

Intended date for commencement of data collection
February/ March 2001

Background information
Please include a brief literature review, details of the problem statement, hypothesis or research questions, definition of terms, limitations of the proposed study

All the recruits on to the CHCN B.Sc. course, delivered in the Faculty of Health and Social Care at the University of the West of England, are First level registered nurses with 120 academic credits at level two. The course of study prepares them to work independently within their professional remit in community settings. As practitioners on completion of the course they require a high level of critical thinking skills and an ability to reflect in action. The module in which they engage with self-assessment focuses on developing the students' communication skills with a view to optimizing their knowledge of skills required in assessing and intervening in client care. This includes looking at counseling interventions and the wider context of debates surrounding partnership with clients. Bandman and Bandman [1995] argue that reasoning, analyzing the use of language and the ability to weigh evidence are fundamental to critical thinking. Within curriculum development in nurse education the emphasis is on the preparation of independent, flexible and self motivated practitioners capable of evaluating their own skill and performance [UKCC 1986,1990] By enabling students to engage in the process of self assessment it has been advanced that these skills are enhanced.

Personal development including what Bradshaw describes as 'critical reflection' [1989] is regarded as fundamental to the role of the professional nurse. Brown [1990] argues that self-assessment strategies enhance students' self-awareness. Rawlinson [1990] suggests that this then impacts on the quality of nursing care. This study therefore seeks to examine whether the element of self assessment, which the respondents have been exposed to during the course of their studies, affects the way in which they act in clinical practice or indeed whether there are other factors experiencing on this aspect of professional life.

Plan of Investigation, including research design/method

Please include details of your research design; method; measurement devices and/or instrumentation; sample selection and size; data collection and analysis; time scale; location of project, cosigns and resources. Also attach any measurement tools: questionnaires, interview designs and patient information and/or consent sheets.

A postmodernist analytical framework will inform the research design. According to Fox (2000) this type of research framework lends itself to collaboration between researcher and respondent. Indeed he would argue that one of the underlying principles of the postmodernist paradigm is in valuing the contribution of all in the development and acknowledgment of the research endeavor. This relationship he considers to be a fundamental precept of the ethical framework in which the research takes place. Given the topic of inquiry in this research project the intention would be to involve the respondents in generating the research design and program of study.

Doherty and Elliott (1999) argue that it is insufficient to cast the subjects of research as merely a user group. This infers that the respondents should be actively involved in the gathering of the evidence and in interpreting its ethical significance. One would extend this argument to suggest that the respondents in this study should be included in the research agenda and the dissemination process, which may emerge from it.

In order to meet these criteria a broad outline of the research methodology will be given and any amendments will be discussed with the supervisor of studies.

The fieldwork will consist of a qualitative study in which 6 to 8 respondents. This will involve inviting them to participate in a focus group discussion on three occasions at monthly

intervals. The purpose is to set the agenda and give opportunity to develop the emergent themes. The respondents will be asked to reflect on the progress of the study and contribute to its ongoing design.

The focus group discussion will be audio recorded and field notes will be taken. The transcripts of the audio recording will be analyzed using critical discourse analysis in order to examine the complexities of the discussions. Transcriptions will also be analyzed using a computer-assisted package such as NUDIST for evidence of the emergent themes and links between them.

Population

Please include details of what your sample is representative of, inclusion and exclusion criteria, how recruited, number of participants, risks and benefits, time commitment required of participants, physical screening processes, the process of obtaining comment.

A purposeful sample of six to eight former students will be recruited from the previous two cohorts of students who have attended the Working with People Module of the Community Health Care Nursing Course. All of these students have been exposed to self-assessment within a discrete program of study.

In the first instance members of the former student group who have expressed an interest on the ongoing developments in self-assessment will be approached. They will be invited to participate in the project. To inform this process they will be sent an information sheet and consent form. The information sheet will clearly outline:

- the purpose of the research
- the rationale behind the postmodernist approach and the implications for the development of the project as a collaborative endeavor
- options for participating and 'opting out' of the research
- methods of data recording, transcribing and confirming the accuracy of interpretation
- that the tape recorded material and transcripts will be destroyed on completion of this study and will not be used for further research

The respondents will be located by personal contact and invited to participate in the study by letter. They will be advised that the research design will be determined in consultation with them but that in principle they may expect to attend three one and a half-hour sessions at monthly intervals. Depending on where the respondents are located these sessions will be held on the UWE campus most convenient to the majority of participants.

In keeping with a postmodernist research methodology the respondents will be asked to comment on any materials generated as a result of their participation in the study.

The students will be sent a pre focus group questionnaire to elicit some baseline information. The assumption will not be made that as module leader I would have access to students past work unless during the research process the group decides that it would be appropriate to access this source of information.

Ethical consideration

Please include details of how you will secure consent and anonymity of participants, maintain confidentiality of data and details of participants information sheet (attach a copy), and how Health and Safety of subjects will be monitored.

Reflection on the nature and interests of the stakeholders in the research process highlights the impact the context and power relationships have on the outcome of the research endeavor. In my own case the nature of my roles as an academic and a member of one of the professional groups will have an impact on the process of accessing the research population. For example my role within the university has an impact in negotiating the structures in the university and in gaining ethical clearance to carry out the project. In order to attempt to address some of the power issues it is important that the respondents are able to decide to join the research and are able 'opt out' of the research project at any point. Ideally I would also like the respondents to be included in any dissemination initiatives which emanate from the project. Given that the issue being researched is self-assessment it seems that a research design which would allow the research population to be involved in the design and management of the project would also 'sit' more comfortably with the concept of self-assessment.

The effect of self- assessment on the former students' clinical practice provides the focus of the study. The research question relates to the influence self-assessment has on the clinical decision making of the individuals who have been exposed to it and have completed their course of study. This focus will allow for invitation to be made to former students who are now in employment who have completed the course. This would allow the project to evolve as a negotiated endeavor which 'sits' more comfortably with the nature of the subject of study. Respondents would overtly articulate their consent to their participation in the project.

This approach incurs risks since the respondents would be involved in generating the research methodology and design. For example focus discussion groups will be used to generate ideas and themes in relation to the issues this demands a high level of skill in group management as well as in recording the data accurately. However this approach may have benefits to both parties since the both the researcher and clinical colleagues would be developing their understanding and knowledge of self-assessment and the research process.

This is a key aspect of engaging the respondents in the research design would enable me as the researcher to value their contributions and expertise and enable us as a team to develop our research skills. Cowan (1998) supports this type of approach in describing his experiences of encouraging student groups to engage in action research and reflects on how this enables them to develop their skills of analysis and self awareness.

In order to meet the ethical considerations inferred within a postmodernist methodology therefore the respondents who are to be invited to participate, will be formally asked for consent and will be advised that they can 'opt out' at any point of the research.

Since the purpose of the study is to ascertain whether former exposure to self-assessment on a course undertaken at UWE affects their clinical practice the subjects will be asked to participate in the study in employer non-contractual time. In addition the study will be conducted on university premises and not on the respondents' employers' premises. The reason for this being that the respondents may wish to make comment about their educational development which may be negatively affected by employment structures and practices. As Babbie (1992) observes the research process should never negatively affect the respondent and this caveat takes this into account.

The focus group members will be advised that during discussion they should identify each other by first names only. This is in order to minimize the risk of identification of the subjects when transcribing the data. In addition the respondents will be given numerical identifiers in

the transcribed reports. On completion of the study any audio recordings will be destroyed and will not be used for archival purposes. These criteria will be clearly outlined to the respondents on the information sheet and reaffirmed in the consent process.

In order to meet the criteria laid down by the Data Protection Act all the respondents details will be coded and the details of this coding will be kept separately to the data files. Only authorized personnel will have access to the files. The respondents will be advised that any material stored by electronic means such as on a tape recorder will be used only to inform this research and will not be used for further analysis. The tapes will be destroyed on completion of the study.

The university data protection officer John Elliot has been approached for advice on the use of computer assisted modes of information storage and data analysis. The above discussion takes into account the issues raised such as access and storage of files and use of computer assisted data analysis.

Funding/Sponsorship

Please give details of any funding/sponsorship attached to your research.

The course of study is self-funded. However, it is supported in principle by my line manager Suzie Ventura Acting Head of Community Nursing School in the Faculty of Health and Social Care. Senior members of the academic team are aware that I am undertaking this course of study.

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Name of Module Leader
N/A
The study intends recruiting former students from the Community Health Care Nursing course more specifically the Working with people module managed by Jane Fitzpatrick

Line manager Suzie Ventura UWE school of Community Nursing, Glenside site

Contact details

Telephone Number

Award Title

Describe how will you inform participants and colleagues about the result of your project?

As a result of the research design and methodological approach I would envisage engaging the respondents at all stages of the research project including reporting the findings and further dissemination of the findings. As a formal process, therefore respondents will be asked to verify any transcripts used in the report of the study. In addition to inform any further developmental process respondents may be informed in writing or by face to face discussion or collaboration depending on the context.

Signature(s) **Date**

Student/Originator
Jane Fitzpatrick

Supervisor
Dr. Tim Bond, Bristol University

If applicable, please complete the following

Consultant

Work based manager
Suzie Ventura, Acting Head of Community Nursing School, UWE Glenside.

Resource Head (HAL/TLSU)

Trust/LREC approached (Name and when)

Ethical outcome	Please leave blank

Please note: If your project involves patients, the approval of a Local Trust Ethics Committee will be required and you will need to complete the appropriate ethics committee form. This takes time and needs early planning.

List attachments: (✓)

- Information Sheet
- Consent Form
- Screening Procedure
- Questionnaire
- Letters of Permission
- LREC's Approval
- Liability Insurance
- Letter of support from supervisor

Information for research participants

Project title

An investigation into the effects of exposure to student self- assessment on clinical decision-making in community nursing/ health visiting practice.

Purpose of the study

Six to Eight respondents will be selected from two previous cohorts of students who have attended the Working with People module in the Community Health Care Nursing Program. This module includes a component of self- assessment, which as you are aware, forms the basis of the academic assessment protocol and informs the student's judgement of their competence in their chosen area of communication skills. This study seeks explore if and how educational assessment and in particular self- assessment has informed the your clinical decision making skills.

What will you be asked to do?

You may be asked to:

1. Agree to participate in focus group discussions with other respondents who have completed a Working with People module.

2. Complete a short pre focus group questionnaire

3. Contribute where appropriate to the research design following a postmodernist research approach

4. Give consent to your contributions to the focus group discussion being tape recorded

5. Give your consent to transcription of your contribution to focus group discussion being made and used to inform the development of the study and analysis of the data.

6. You may be asked to contribute to an in depth interview on completion of the focus groups if further clarification of points is needed.

7. You will be asked if you would like to contribute to the dissemination of findings of the project.

Are there any risks or benefits to participation?

It is hoped that participation in the project will allow you to reflect on your process of self-assessment and consider if and how it affects your clinical practice. The sessions will be scheduled out of work hours and not at your place of work so that any conflict of interest that you may experience between your intent in practice and your expectations arising from self-assessment will remain confidential to the project.

What happens if I refuse or change my mind?

There are no penalties for declining to take part. At any time during the research process you can withdraw from the study without penalty and the data collected in relation to your personal experience will be withdrawn from the study.

What will happen to the recorded data and transcripts following completion of the project?

Any data collected by tape recording or transcribed will be destroyed on completion of the study.

Confidentiality

Only the researcher will know the identity of respondents. Any reporting and data analysis will not identify the participant by name.

Consent

Written consent will be sought prior to commencement of the data collection. As described above this may be withdrawn at any time by contacting the researcher.

Consent form

The research data collected will be confidential. You can choose to withdraw from the project at any time.

I understand that the research data will be used to inform doctoral study research and the ongoing work being conducted in the Faculty of Health and Social Care on the development and implications of student self-assessment strategies.

	Circle answer
Have you read the information sheet?	**yes/ no**
Have you received sufficient information about the study?	**yes/ no**
Do you understand that you can withdraw from the study at any time?	**yes/ no**
Without having to state a reason	**yes/ no**
And with no penalty	**yes/no**

I hereby consent to taking part in the research project seeking to explore the effects of exposure to self- assessment on clinical decision making.

Signed: _____

Date: _____

Name: (In block letters) _____

Contact address _____

E-mail/ phone contact _____

Pre focus group questionnaire

Which professional discipline do you belong to?_____

How long have you been in professional practice?_____

How long have you been a community nurse or health visitor?_____

When did you attend the Working with People module?_____

What was the focus of your self- assessment criteria?

_____
_____
_____

Which area of communication skills did you chose to reflect on in your academic essay for the module?

_____
_____
_____
_____
_____

_____

Appendix 3

Overview prompts for first session

Overview of prompts for the first focus group session.

1. Welcome to everyone, thanks for coming etc.

2. Introductions

3. Recap briefing and purpose of the meeting

4. Reiterate consent and opportunity to opt out.

5. Ground rules re. Confidentiality etc. re-emphasise the reason for meeting on university premises and not in participants places of work.

6. **Topics for discussion**

a. What do you understand by the term self-assessment?

b. Are there aspects which are different to assessment?

7. Probe emerging themes. These emerged as subjectivity, support, ownership, changes in power differentials etc.

8. Recap on opportunity to engage in the design of the project. Invite suggestions for this

9. Negotiate future sessions

Appendix 4

Summary sheet sent to participants

Review Commnets

Initial observations

Again impressed by the commitment of getting there despite big hold ups on the traffic scene

Four of us present at this session unfortunately 3 people couldn't make it. To invite to next session

Very complex issues were shared which demand a high level of commitment to the client groups colleagues work with

Better account with the tape recorder this time but still need to be aware of the quicter speech. Imperative to take notes asap. to get the essence of the discussion

Emerging themes

- **The model of self assessment being employed**

All of the respondents seemed to be sharing a model of self-assessment in which a sense of self as an agent with potential to review practice in a way which may result in change.

Self in this sense seems to be an important factor affecting the relationship the respondents engage in with clients.

There seems to be a sense of frustration with others for example within teams who do not appear to have these skills. However there was also a sense of wanting to engage with people who do not have these type of skills where this falls within the individual's sphere of responsibility. There seemed to be two aspects of this the first in order to affect the care given to clients and the second to enable the individual to develop their potential within a community work environment.

Members of the group seemed to have a sense that self-assessment is developed over time but were unclear as to what might be said to provoke it. For some it seems to be part of a gradual process. The question remained however as to why some colleagues seem to have the capacity to develop it and others apparently do not.

- **The complex nature of clinical-decision making**

The comments about decision-making reflect issues related to the client group and to the context in which decisions are made. This again is alos associated with discussions about the responsibility and accountability of professional practitioners.

The discussion illustrated differences depending on the age and context of the client. For example differences in the relationship the nurse has with the client may be as a result of context for example:

A. The nurse may only see a client in a PHC clinic context and for a short consultation which, may occur only infrequently. This may be initiated by the PHCT or by the client themselves

B. The nurse may see the client in their home environment. This is often by referral from another agency such as a hospital referral or by a GP

C. The nurse may see the client in both settings over a sustained period of time

There may be assumptions made about the nature of the consultation by the client and the referring agent.

In all the illustrations offered the primary responsibility was seen to be towards the client and in particular working towards client **autonomy.**

There were also issues related to the nature of family or carer dynamics impinging on the nature of decision-making.

- **Autonomy**

In terms of client autonomy this was generally seen as the ultimate goal. This could be compromised to some extent however if the client did not appear to make an appropriate decision. For example if a woman did not turn up for a regular family planning appointment and this could compromise her future health the nurse may prompt an appointment by ringing the client with a reminder.

A different framework would be employed where a client actively declines a service. For example if a family refuses services or wishes to remain in the home the client's right to decline the service would be respected.

- **Confidentiality**

The nature of confidentiality was a key concern in deciding how to engage the client in care. This was particularly evident when the nurse may have to contact the client in a non direct manner about Family Planning appointments.

This may also be an issue wen working with clients who rely on others for care.

When dealing with young people this was also an issue since young people may not have advised their parents of the nature of their consultation or indeed that they have sought advice about a medical matter.

- **Duties and obligations**

Problems arise when the client is not the only person involved in making the decisions in respect of care. For example if parents wish to be involved in complex care giving the overriding responsibility to assess their capabilities would be seen to rest with the nurse. This is also linked to the sense of the nurse as a teacher and educator. In the scenario described the overriding concern is for the safety of the child. Although the parents have a responsibility in decision-making the nurse would be the expert

making the judgement about the carer's capacity to carry out complex and potentially life threatening care.

Although this part of the discussion seemed to relate to professional accountability and expert knowledge a sense of the personal responsibility towards the child seemed to emerge. Also a sense of the ongoing relationship with the family which, is sustained over time.

Appendix 5

Examples of vignettes used in second focus group

Vignette 1

You have a client or carer who is unsure about an aspect of their spouse's treatment regime. They want to maintain independence but cannot seem to grasp what is required.

1. What factors would you take into account in assessing the situation?

2. How would you facilitate their learning process?

3. What factors will affect your decision-making in relation to this course of action?

Vignette 2

You see a client in the course of your practice, during the encounter you become aware that the client or the carer is not following the treatment and care plan agreed although they deny that this is the case. The effects of this deviation from the agreed care plan can have severe detrimental effects on the prognosis of your client.

1. How would you assess the situation?

2. Are there any differences from the first scenario?

3. What would form your frames of reference? For example what knowledge would you draw on?

4. What would you do in consequence?

5. Why would you act in this way?

6. Does self-assessment affect the way you would act in either case?

Vignette 3

You are having a conversation with a student who is starting the Community Nursing course. They ask you about the assessment process on the course, both in the theoretical and the practical aspects. They are concerned how they will achieve their learning outcomes.

1. How would you describe the assessment process from your perspective?

2. What issues would you emphasise to the student?

3. Assuming that you are participating in their learning process in some way. How would you engage with them in facilitating their development of their portfolio?

4. What would be the main points you would want to emphasise?

5. How would you suggest they proceed?

Appendix 6

Semi-structured questionnaire used to probe emergent themes

Semi-structured interview schedule.

Jane Fitzpatrick

Dissertation re self-assessment and ethical frameworks

Introduction to the interview
Purpose of the interview

To begin uncovering your views on self-assessment. This will complement the work I am doing with the focus group.

There is potential to run a second group to see if there are similarities or differences between people who have been members of the WWP module.

The second group could be of people who have found themselves changing direction following the course.

Today's agenda is to look at how you perceive the concept of self-assessment and your perception of its impact on your professional development.

Ground rules

Check consent form and respondent clear re the information sheet.

Will use tape recorder as stated on the information sheet. The tapes will be destroyed on completion of the project.

Any questions before we start?

Agenda for today

To begin examining your view of self-assessment

What it means to you

How you engage with the concept

What your experience is of the proccss c.g. fcclings it may evoke/ influence of others

What helps or hinders the process

How it links with other developmental or learning processes

Does it affect the way you engage with the world?

Interview schedule

Biographical details

Name (will be coded)

.....

Gender	male/female
Age group	20-24 25-34 35-44 45-54 55-60

Ethnic group

.....

Discipline

Please circle HV, DN, CPN,CCN,PN PUHN, other please describe

Questions

1. What were your three self-assessment criteria about?

2. What topic did you write about for your essay?

3. What does assessment mean to you?

4. What would you see as its key purpose?

5. What does self-assessment mean to you?

6. What helps or hinders the initial engagement with self-assessment?

7. Is there any aspect of the culture of the environment that affects the process?

8. What skills do you need in order to engage with self-assessment?

9. How do you engage with the concept?

10. What is your experience of the process? E.g. feelings it may evoke/ influence of others

11. How does it feel developing your own criteria as you did on the course?

12. How did this affect your perception of what you were hoping to achieve?

13. Is there anything that has made you continue to use any part of the self-assessment process? What has affected whether you retain an element as part of your learning repertoire?

14. How does it link with other developmental or learning processes?

15. Does it affect the way you engage with the world?

16. Has it had any particular influence on your approach in practice?

Appendix 7

Examples of diagrammatic representation of coding and linking using NUD*IST

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++ Retrieval for this document: 10 units out of 37, = 27%
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don't know if it comes back to the issue of role models if you see a
ractitioner operating like that if you take that on board 1
1) /assessment
? 2) //Free Nodes/self
? 3) //Free Nodes/assessment194
2
1) /assessment
? 2) //Free Nodes/self
? 3) //Free Nodes/assessment194
ou do take some of that on board 3
1) /assessment
? 2) //Free Nodes/self
? 3) //Free Nodes/assessment194
4
1) /assessment
? 2) //Free Nodes/self
? 3) //Free Nodes/assessment194
t whether you actually learn it an academic sense 5
1) /assessment
? 2) //Free Nodes/self
? 3) //Free Nodes/assessment194
6
1) /assessment
? 2) //Free Nodes/self
? 3) //Free Nodes/assessment194
t is obviously one of those things that you accumulate as you said over
length of time and it is only when you do something like this that you
alise actually the complexity of things of what we are actually doing
ecause I just take it as a daily job it is my job I go and do it 7
1) /assessment
? 2) //Free Nodes/self
? 3) //Free Nodes/assessment194
8
1) /assessment
? 2) //Free Nodes/self
? 3) //Free Nodes/assessment194
t is interesting if we think about ways of doing things OK I am doing
is like this but I wonder what they think about it I know we think
bout it but what did they think about it It is your approach as to how
ou can deliver that or you can express that thing because you are
xpressing an interest a reason why whether it is an interest or whether
t is your work if you have interest and look at another side of it and
hat person and how does that help them does it fit the bill? Could we do
t differently 9
1) /assessment
? 2) //Free Nodes/self
? 3) //Free Nodes/assessment194

(6 4) /Judgement/family
(6 5) /Judgement other professional groups
(6 6) /Judgement/own profession
(7) /ethics
(7 1) /ethics/duties and obligations
(7 1 1) /ethics/duties and obligations/professional code
(7 1 2) /ethics/duties and obligations organisational policies
(7 1 6) /ethics/duties and obligat moral obligation
(7 2) /ethics/Integrity
(7 2 1) /ethics Integrity/Profession
(7 2 2) /ethics/Integrity/organisation
(7 2 3) /ethics/Integrity/work context
(7 2 3 1) /ethics/Integrity work context/colleagues
(7 2 3 2) /ethics/Integrity/work co ntext/client
(7 2 3 2 1) /ethics/Integrity work context/client/self
(7 2 3 2 2) /ethics/Integrity/work context/client/family
(7 2 3 2 3) /ethics Integrity work context/client/carers
(7 2 4) /ethics/Integrity/personal
(7 2 4 1) /ethics/Integrity/personal knowledge
(7 2 4 1 1) /ethics/Integrity/personal/knowledge/condition
(7 2 4 1 1 1) /ethics/Integrity personal/knowledge/condition/prognosis
(7 2 4 1 1 2) /ethics/Integrity/personal/knowledge/condition/treatment
(7 2 4 1 1 3) /ethics/Integrity/personal/knowledge/condition/potenntial outcomes
(7 2 4 1 2) /ethics/Integrity personal/knowledge/situation
(7 2 4 1 2 1) /ethik s/Integrity/personal/knowledge/situation/family circumstances
(7 2 4 1 2 2) /ethik s/Integrity/personal/knowledge/situation/informal support
(7 2 4 1 2 3) /ethics/Integrity/personal/knowledge/situation/agencies
(7 2 4 1 2 3 1) /ethics/Integrity/personal/knowledge/situation/agencies/health
(7 2 4 1 2 3 2) /ethics/Integrity/personal/knowledge/situation/agencies/social services
(7 2 4 1 2 3 3) /ethics/Integrity/personal/knowledge/situation/agencies/environmantal health
(7 2 4 1 3) /ethics/Integrity/personal/knowledge/interpersonal skills
(7 2 4 2) /ethics/Integrity/personal/experience
(7 2 5) /ethics/Integrity/ethics
(7 3) /ethics/relational
(7 3 1) /ethics/relational/knowledge
(7 3 1 1) /ethics/relational/knowledge/codes of practice
(7 3 1 2) /ethik s/relational/knowledge/exp rience similar situation
(7 3 1 3) /ethik s/relational/knowledge/b efs values
(7 3 2) /ethics/relational/teaching skills
(7 3 3) /ethics/relational/support
(7 3 4) /ethik s/relational/responsibility
(7 3 4 1) /ethics/relational/responsibility/resonsibility for
(7 3 4 2) /ethics/relational/responsibility/responsibility to
(7 3 4 3) /ethics/relational/responsibility/letting go
(7 3 4 4) /ethics/relational/responsib lity/s tared
(7 3 4 5) /ethics/relational/responsib lity/a t ng for another
(7 3 4 6) /ethik s/relational/responsibility/intervening for another
(7 3 5) /ethik s/relational/power
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(7 4) /ethik s/ justice
(7 5) /ethik s/intuition
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(I) //I ree Nodes
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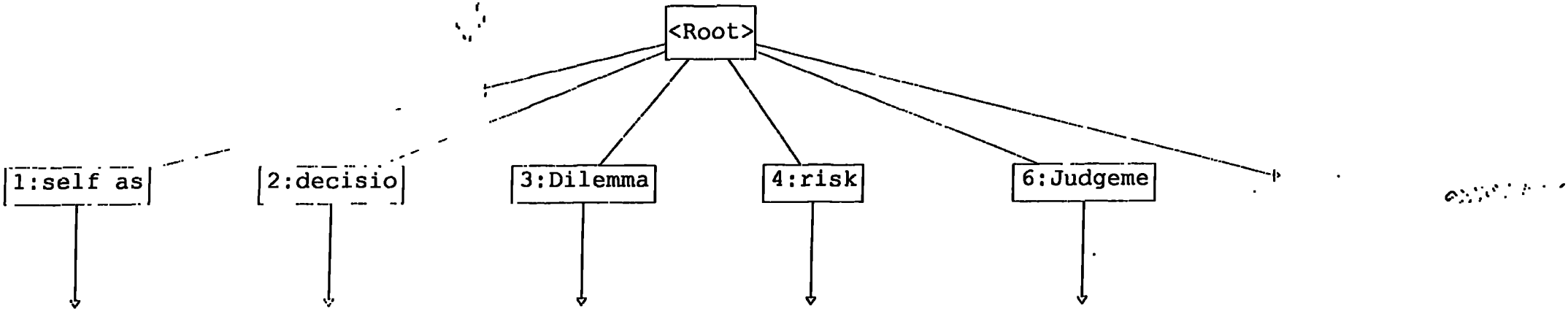
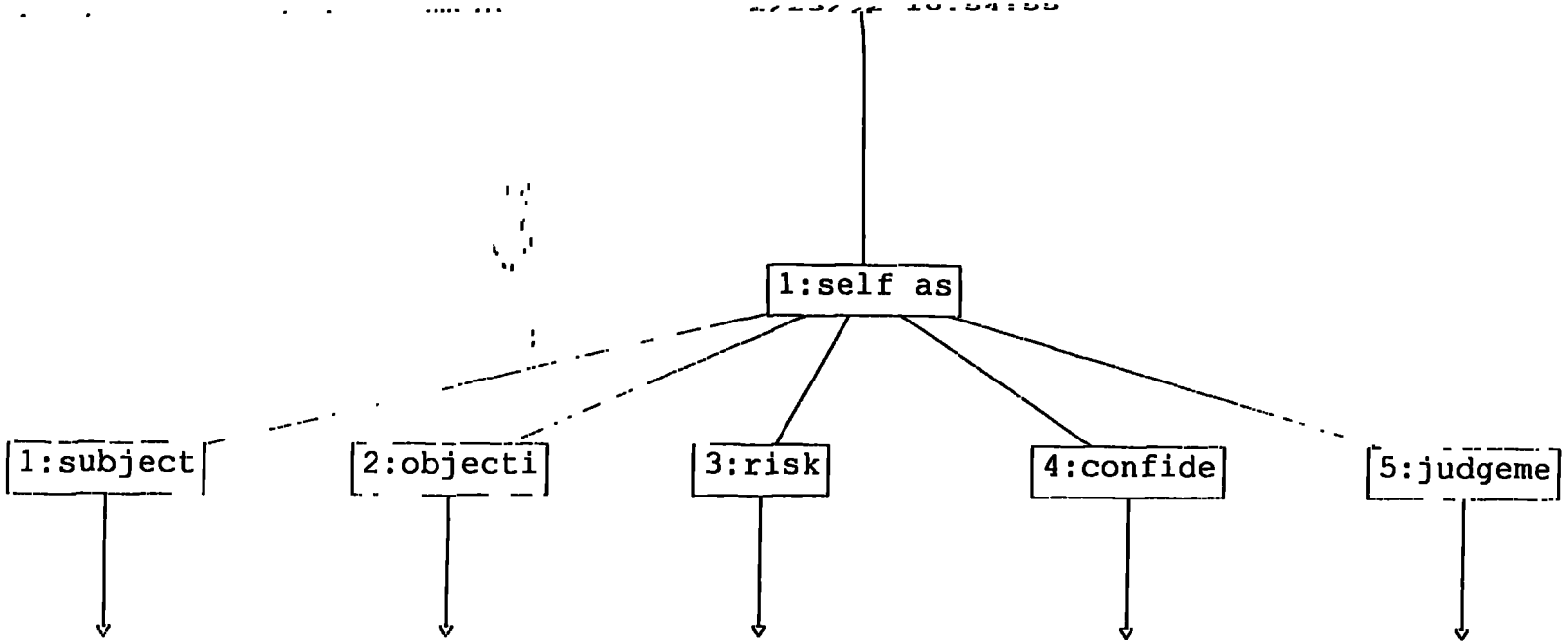
(I 1 1) //I ree Nodes/self assessment/objective
(I 1 1 1) //I ree Nodes/self assessment/objective/measurement


<Root>
1:self as
2:decisio
3:Dilemma
4:risk
6:Judgeme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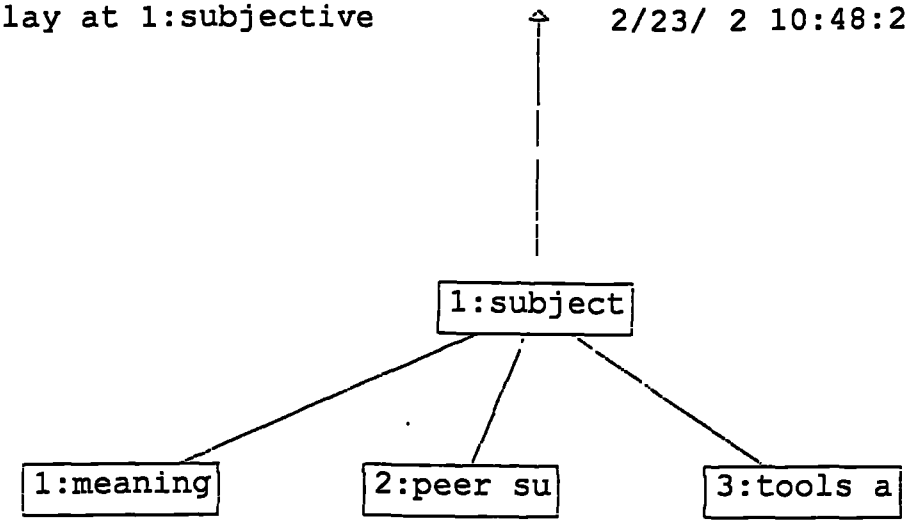
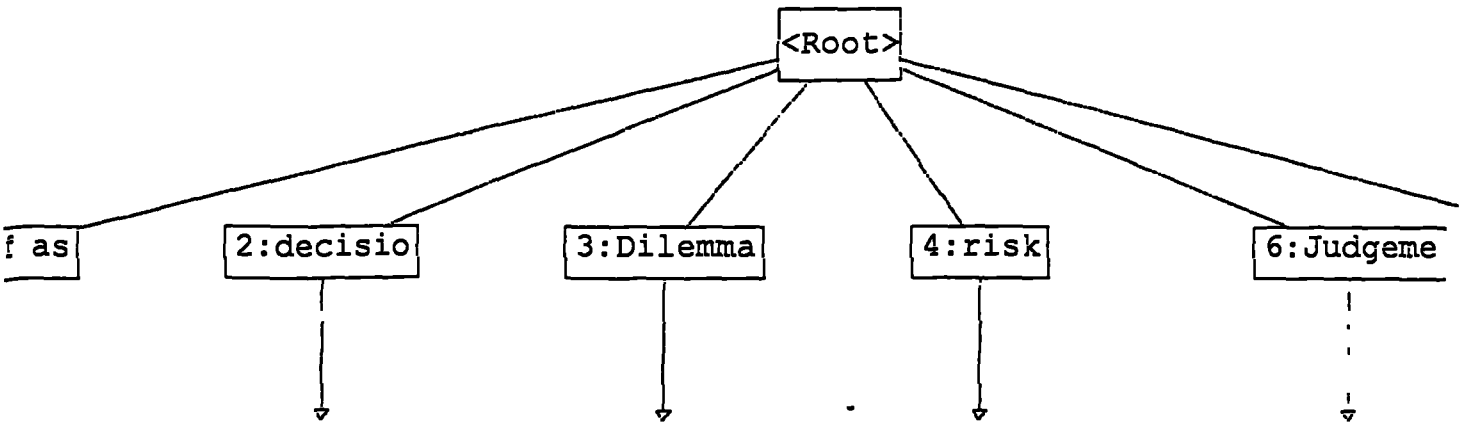
1:subject
2:objecti
3:risk
4:confide
5:judgeme

:ee Display at 1:subjective 2/23/ 2 10:48:23




<Root>
f as
2:decisio
3:Dilemma
4:risk
6:Judgeme

Q.S.R. NUD.IST Power version, revision 4.0.
Licensee: UWE.

PROJECT: Jane, User UWE, 10:59 pm, Feb 22, 2002.

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+++ ON-LINE DOCUMENT: transcript fg 3a
+++ Retrieval for this document: 6 units out of 740, = 0.81%
++ Text units 67-70:
you were talking about a family planning situation in terms of how if somebody hadn't 67
(4) (7 3) (T 4) (T 5) (T 7)
turned up ,to the clinic you ring them don't you and then ask them to come but we had a 68
(4) (7 3) (T 4) (T 5) (T 7)
discussion about how you would go about that if the person has not told the parents that 69
(4) (7 3) (T 4) (T 5) (T 7)
they have come and they need a prescription or if they have said that they don'' want to 70
(4) (7 3) (T 4) (T 5) (T 7)
++ Text units 77-77:
there was a bit about whether the child would give their consent and there was the parent 77
(4) (7 3) (T 4) (T 5) (T 7)
++ Text units 517-517:
a sense of shared responsibility in terms of integrity on whatever level and there is 517
(4) (7 2) (7 3) (7 3 4 3) (7 3 5)
(T 1) (T 2) (T 4) (T 5) (T 7)
(T 8) (C)
++
+++ Total number of text units retrieved = 6
+++ Retrievals in 1 out of 4 documents, = 25%.
+++ The documents with retrievals have a total of 740 text units,
so text units retrieved in these documents = 0.81%.
+++ All documents have a total of 3178 text units,
so text units found in these documents = 0.19%.
++

Appendix 8

Example if initial coding from first focus group.

Transcript 1 focus group 19.6.2001

Six participants

1 CCN, 1PN, 3DN's 1CPN

Example of initial coding

speaker	text	Field notes/comments *Italics=initial coding* **Bold=observations on events**
J	19 June 2001 19.6. colleagues who took part in the working with people module when they were on the CHCN course	
J	I am going to start off with some broad questions about assessment and what you think assessment is about	
J	The first one is what does assessment mean to you?	
B	Just a general concept of establishing a *given level* so something about a level	*Measurement*
Sh	Is it a judgement really?	*measurement judgement*
J	It is a judgement.	
J	I should have seated you more towards each other not towards me necessarily. I am not here as a teacher today!	
Sh	A *judgement of ability*	*Judgement* Humorous
J	So its something about a *level and a judgement*	**I had seated the chairs in a circle but the members of the group seemed to have regrouped towards me? Needed to clarify the dialogue aspect of focus groups?**
L	Measuring something maybe	
B	But the question is are you *measuring something at that point in time or are you looking at a broader spectrum a longer thing a continuum.*	
L C	Yeh yeh	
B	*Is it a snap shot of today and how you are today or are you looking at a whole picture*?	*Theme of measurement and judgement linked to temporal aspect*
J	So it could be something about what you want *to achieve* ?	

J	So it could be something about what you want to achieve today or it could be something about a developmental process and how you are going to move from this position to another one?	**Others interject affirming this view**
S	Its about observation and having a *tool to measure in a standard way as a formal assessment*	***Measurement tools***
Sh	Use as a measuring tool	
J	So there might be something about what you *need to measure* in a standard way hence the measuring tool?	***Purpose of assessment***
Ju	I suppose it might be *objective or subjective*	***Objectivity and subjectivity***
	Mm mmm	
B	I suppose it depends on the framework of what you are assessing	
J	I just *wondered how you could make assessment objective*	
	Long pause	
L	That's why *you need a tool isn't it?*	**Affirmation again ? who**
B	If you have a specific like guideline yeh Like for example if you were thinking of a nursing assessment like pressure area care You would use a *specific tool* being used which is verified and validated To say that yes if we use this this will predict the risk of pressure sores so if you want to make an objective view you would have to *have measurable aspects for the score*	**This seemed to be reflecting a very 'objective' view of assessment' I did not comment on this at this point** ***Objectivity and measurement tools***
several	Yeh	
J	So something like a pressure assessment tool is dependent on other forms of knowledge so you would have to assess something about the nutritional state of the individual the skin integrity but you are using other things as an indicator of the assessment but there are different assessment tools which look at different aspects	**Commented here but aware might be affecting the discussion ? is this OK**
S	It is used for older people It is for looking for people *at risk It* is part of mental health There is a lot of pressure on to do a risk assessment because of the high profile of mental health patients and people who have major tragedies. The *focus of risk is a big issue* at the moment and these are statutory rules. We have statutory forms again it	**Very quiet voice** ***Risk Criteria***

	has to meet *certain criteria.* The form is designed as a questionnaire about ageing and it has just been implemented in March 2000.	
J	That's quite interesting because it feels as if in that context it is actually being made more overt and specific as a result of litigation. Do you see any similarities with educational assessment? Pause	
S	I don't think so … *but I think if you take the whole thing about risk I think there is the same perception of risk in education as there is Yes in the loosest sense you might think about the risk of not passing. Did I do enough work if risk is seen in that context but I don't think risk is the same to be assessed unless it is education and evidence based practice and then you are able to change it over* Does that make sense?	***Risk, the nature of risk*** ***Parallels between practice and education***
J	I do I do I don't know what anyone else thinks about risk in terms of in a professional course one of the things I seem to come across is in people feeling that they are taking a risk in allowing the student to practice	
B	Yeh again they will be at risk if they are not meeting the criteria for the assessment so if you have a student who you can see *from your observation of their practice they are not safe then yes you can use the idea of risk there* then again you are using **your** assessment it is important *Is your assessment is how someone else would assess?* So again it is using your own background knowledge and how you have been taught to assess that person	***Risk*** ***Judgement and accountability***
?L or C	So I might see something but someone else might see something quite different	
Sh	But if you are talking about medical risk assessment that is different than educational assessment	
J	But I am just asking are there any similarities?	
Sh	I suppose that you are assessing something as if it is. It has to be similar because in that point view. But I think it is completely different really because there are now cardiac risk assessments that you can do an objective measurement of how you know how someone how the myocardiac scores To have an objective measure of how How someone comes out with a heart attack in the next ten years **That's** a risk assessment . I don't see that as being anything similar to assessing education standard	***Objective measurement*** ***Risk assessment***

	Mm	
Ch	Are they still similar because you have still got criteria	***Criteria***
L	Yes you are still meeting criteria	***Achieving criteria***
B	And there is still that thing that it will come back onto like your accountability For instance if you hadn't assessed someone for coronary heart disease if you hadn't done it whatever and that had come back to you if you hadn't done it sufficiently if you didn't assess somebody in the workplace *that is where it goes like into your accountability and you are accountable if like you say that student has been assessed as a pass when in fact they are not then that then to me would be an element of risk because it would you know you could be held in some ways accountable for passing that person who isn't who has been assessed as being suitable to pass but isn't so then that would be a risk and accountability its about being* clear	***Accountability*** ***Judgement*** ***Risk***
J	For me the issue of assessment overall is is a lot of *supposition that you can actually objectify it but actually what it comes down to is that you cann't I think in medical risk you are using other indicators such as knowledge of physiology and nutrition on a different level than you can in education. But there is risk assessment with any sort of assessment it could be argued and if you looked at something like the Bevery Alert case for example if you look at the report educationalists were actually raising issues about her practice even before she actually completed her studies and then we say the result of that. It is an issue of accountability but it is at a different level it's the perception of what it is about*	***Objective measurement, parallels between practice and education Accountability Perception***
Ju	People would be influenced by the statement of the truth. I would take more risk with someone who was believable	
?	So?	
Ju	This would balance out with safetyness	
J	Would that be if so for whoever was working with the student perhaps	
Ju	If I asked a student to go and see a patient to carry out a task then I would assess that risk as to what could go wrong whether if they did make a mistake if *clinically that is dangerous the then base that assessment on that on the ability to do that it adds caution whereas if I'm assessing to carry out a task that is perhaps didn't involve a task ....or perhaps*	***Relationship with student and client Duty of care***

	they ended up doing a big piece of work and have gone down the wrong track which retrievable which is annoying but it is retrievable then I would be prepared to take the risk There is a balance of the outcome	***Allowing student to take risk***
J	Thank you	
J	So What I was going to say what then do you think is the key purpose of assessment in education? Is it about measuring something or seeing something. So it could be based on something informing	
S	It is about development it must be based on um an overall thing that allows you to move on a step in the ladder	***Assessment as developmental process***
J	How would you see self-assessment What does self-assessment actually mean?	
B	Well its about development a learning and moving on looking for a strength or weakness	***Strengths and weaknesses***
J	So is it more at the beginning phase?	
B	I would see it at any phase, Yeh a beginning phase but I would also see it as. I would also say you have to have a) willingness of the person to do it and b) you have got to have the confidence to do it . I don't think you could ask it of anybody they have got to know what is expected and what to do for themselves in some ways because if you don't know yourself then I don't see... if you don't have the confidence to say oh well I can do this or I am not very good at that then I don't see how it would particularly work	***Confidence Willingness***
Sh	It works with reflective practice I find though You can reflect on what you are doing and then make a judgement on how you do it better so that through yourself it is understanding it isn't it but to understand it you have to do it	
L	Understanding the concept is important	
J	Understanding the concept. You are also saying something about confidence. Do you think that confidence can be developed?	
B	Oh yes. I mean I don't think you have to have it I don't think you have to be very confident to start with as long as you have enough confidence to know what you are actually doing and time to develop it and actually understand	***Confidence and support***

Appendix 9

Extract from the District Nurses' discussion on perceptions of their service.

Example of transcript re factors affecting District Nursing practice

Speaker	Dialogue
B	I think it is quite often not having been in the post that long there are actually quite a lot of patients who people were just popping in to. But you think hang on you don't need to do that however it gave the team the security they knew then that they weren't going to get the difficulty of call at ½ Past 4 on a Friday afternoon about such and such and there was no need of it. But to me if you go in and you are treating somebody you are often starting off daily and then alternate days and then three times a week and you gradually it is like a weaning process you are gradually weaning them off and handing back the responsibility to them to make sure that they then eventually realise that they are not suddenly tied to our purse strings as it were. They are actually able to go out and manage their care on their own and report to us if there is a problem whereas when you first go in it is my 'God' the nurse does everything don't touch it!
A	But those nice visits in a sense can be quite self centred and you can have a very comfortable time if you are a nurse who doesn't like to feel threatened and your skills are maybe, or you see your colleagues as far more competent than you it is a nice safe way of keeping a nice safe caseload
B	Because you can actually go in and say oh well I will see Mrs so and so and so and so and then you have a cushy morning really
A	I'd hate it if I ever got like that. But as professional that is horrendous but it does happen and it is not just someone like yourself who takes over and has a fresh look at things you think what on earth are they doing when we have got waiting lists how on earth when we have got people really in need and we are playing a numbers game and block everything so then again it is quite a problem and it hides quite a lack of competent skills.
B	It also the sort of people who like you say who with the clinical skills feel quite threatened it's a very good way of saying well I have had a very productive morning and I have seen Mrs So and so and done this but actually you have talked about the weather and have done absolutely nothing and for instance I have a situation like that which happened but the patient when I went there were actually three problems which weren't being resolved for at least the last six months and the person had been going in on a weekly basis and the wound had been dressed but because the topic had never been brought up
A	But that is also very selective you will find when professionals go in but I would think that when you go on a course or go on placement or you go with a colleague and they don't ask questions which you know would promote maybe some more skills but they don't want to know lets leave it as it is and they go out of the door saying bye and that makes them feel quite good and I think that is very sad It is very sad and quite scary because what kind of a nurse would we get

	are we going to get a proactive competent one with up to date skills or are we going to have this nice person who comes in and says how are you today lets sit down and have a chat with the new baby or whatever it is very sad
C	I think it is to do with skill mix as well in the team we have three different grade nurses to have different grade competencies and you have the same grade nurses going in week after week and so you can have one nurse bath Mr so and so week after week although it is probably not a district nursing task and then perhaps trainers notice
B	And suddenly you notice that's not particularly safe but hey that has been happening for the last two years
A	You are played off aren't you? And they say well they did that for me and you say well that is not really a good idea if I do that and they say well they did that for me and you think well crickey!
C	Why hasn't sister come in to see me?
A	Because sister knows how to do it!
S	Why am I not seeing the sister why am I seeing you?
A	She does this for me
Moderator	There are also different levels that you are operating at there is one level when we are talking about working directly with the client isn't there but there is also another sense of the responsibility you have to a wider commitment to the caseload so because you are senior members of the team you are deciding as to whether or not you terminate this particular contact or you adjust the way that it is delivered or whatever because of the number of people who require the service
B	But it is also quite interesting because I have some patients one of whom I have to be very careful because one of my members of staff will put her name down to visit specific people all the time and she doesn't like it now because I actually do the workbook for the whole week and allocate over the whole week and try and work out if we are going to need cover or not and I now try to see all the patients at least once every six weeks everybody else is going in, in the meantime but it is actually quite interesting to go in and see what certain members of staff are doing and if it is what is documented and it is very strange because you then have this responsibility that you have to think well hang on I am not just going in to do this dressing but what is on that leg already is it what I prescribed to be done you know why has it been changed and it is then that you are back at this other level of responsibility for the safety of your patients and the health of your patient

Appendix 10

Example of the Practice Nurse's view of her engagement with self-assessment and the discussion prompted by this.

Example of the discussion on self-assessment prompted by the PN respondent's example of using self-assessment within an isolated practice situation.

Tape starts after beginning of a conversation about how we develop a sense of self and self-awareness. It had started from a discussion about what our sense of self-assessment is and what prompts development in this way. Members of the group were relating descriptions of colleagues who they felt do not convey the same sense of self-awareness in respect of their communication skills in particular. Later in the tape a distinction is made between self-assessment of competency as described as doing a task and the communication which accompanies a task.

Speaker	text	Comments/field notes
S	Because for some of us we sort of develop on our own don't we? Developing our self-assessment we haven't anyone to bounce it off. Working on our own in an environment that I work in. We have little contact with others is what I am trying to say. We don't have the opportunity to discuss things so you naturally self assess.	*Using self-assessment in an environment without peers own own discipline to bounce ideas off*
J	But does everyone self assess?	
B	Yes they do	
S	Yes constantly we do In fact the last person I say this morning was quite real. Whilst I was doing what I was doing I was thinking I should have done this I should have done this I should have done that or you know, this is because he keeps coming in on emergency appointments and so on because its an emergency appointment you just do the emergency thing and you think I should be handling the time, I should be handling the time, and I should be doing this differently, and next time he comes I shall remember to ask him about this or this just to make sure that I have covered all the areas. Do you see so you do it automatically	*Example of situation self-assessment is employed*
B	Is it because of the profession we are in? If you put this to someone outside the profession would they come up with the same answers? Would they say that they continually review? Now I think that they would, they wouldn't again call it self-assessment. But they would be doing it.	*In situ theorising is it in our profession?*
S	Its very interesting because since I did this module um Phil has been looking at assessing their continuing professional development in surveying he works as a surveyor and they have courses but they don't have any in house way of continuing the assessing and he is fascinated by it which is very interesting so there are professions which don't have that	*Comparison with surveying*
J	I think people selectively self assess and look at some aspects some may self assess our practice You could self assess the approach you know the way in that personality comes over *? bit here re colleague*	*Selectivity in S/A Purpose*
B	Do you see that.. do you think that is perhaps because she is not comfortable with that aspect so she therefore self-assesses that part which she is competent at	*Self assessment as a threat*
J	No I think she is oblivious to it I don't think she sees that	*What causes self-assessment to*

	as part of what she needs to self-assess. Some of those things are very acceptable within the practice but some of the patients find it difficult. The fact that she confuses, she is busy and not focused but the work that she does is fine it is bog standard	*occur*
B	Well historically it may be OK	
J	Part of it doesn't seem to be part of our work	
Moderator	I am just wondering about June's question is there a difference between assessing something which could in a sense be objectified and a competency that doesn't have to necessarily be seen as part of yourself as such does it it is a task that any nurse may be expected to do so for example if you are checking the IV or whatever you can almost externally check whether you have done it according to the procedure or according to the instructions or something	*Is there a distinction between assessment of the person and the things they do as in carrying out a task*
Moderator	But the way in which you approach the patient. in which you check the IV may not be seen as part of the integral process	*What are we including in assessment?*
B	Now you see that is the problem with the member of staff I have she can do the task and she can do that but she is oblivious to the fact that when she goes to people she will call them my darling my love or whatever she has no perception that that can be quite off putting and patients don't like it she doesn't realise that she comes across as if she is always rushing and it is something she doesn't realise that she is coming across like that which is why we are looking at the interpersonal skills within the self assessment. It may be seen as a criticism rather than as well yes Well yes as a criticism	*Problem with defining criteria*
J	She may also be reflecting a culture of where she has come from and that could be the norm for that particular area.	*Does prior experience of other cultures affect it. Does organasational culture mediate the experience?*
B	I think it is because before she came to us she was in theatres therefore she was dealing more with patients who were under anaesthetic or coming around from anaesthetic	
S	She didn't really have to communicate	
Moderator	And the time she had was very short and specific	
B	Yes and you could imagine her bringing a patient out of anaesthetic saying "It's all right me darling its OK and the way she has may be acceptable	*Example of disparity of experience in different nursing cultures*
Moderator	She had a mothering sort of attitude?	
B	Yes but where she is now is not acceptable	
Moderator	It is to do with the culture and the support network	*Support networks*
J	Do you feel that you do your job well you are asked and	

	then someone is criticising In a manner that is not unpleasant but is confusing or difficult	
S	And those sorts of things are more difficult to take criticism on If for example someone says well look you put that plaster on wrong then so be it no matter what you cannot argue with that but if someone says your manner to that patient is not right you almost go well what are you judging are you judging my manner on that that you would have which would be different and that is more of a personal thing that is harder to take *agreement from others*	*Difference between assessing artefact and personal attributes*
J	It would be seen as a personal criticism	
B	It is harder to take and accept	
S	Yes it is harder to accept	
J	But if you know you were rude to someone then you could accept it	
B	It is sometimes easier to take if for example you say for example you know your manner has been a bit off today Somebody might say well it connects up with something else but if it is part of their personality trait it is very difficult to	
Moderator	But what I cannot get at now in my experience some types of self assessment are quite reflective and expect you to be whilst others I suppose it also depends on the motivation for others for the job that they are in	
B	Some people are in it for 9 to 5 and they will never reflect because they don't have the motivation they just get up each day and go to work	*Nature of work environment and personal motivation*
Moderator	And there are all sorts of different reasons for that I come across people who are in the job for 9 to 5 or whatever and are taking home the money but somewhere along the line they have lost their enthusiasm for the particular field that they are in	
B	You see that to me the person that I am if I was de-motivated in the job I would have to leave because I couldn't go to work every day just to go to work it wouldn't be me so I would have to then reflect where you need to go but it does seem to link to personality perhaps that don't have either the ability or the will to actually look at things and analyse them	*Self motivation as prompt to review skills and personal development*
Moderator	But is it also to do with confidence and the support within the team. So for example in the team in which you are working I have a sense that you are a supportive team and people will discuss things in a constructive way I mean for example with your colleague in the way in which you are trying to enable her to reach for her to look at herself in terms of community practice but you seem to have made a commitment to do that although it might take a longer time	*Support, Constructive dialogue and challenge*

B	Because they may not have the motivation	
J	People do approach things differently though Again discussing a colleague who very much likes ?*to consider could work at a higher level but* asserts that this is the level I am working at whereas that particular person says well I don't get paid for that but she is perfectly adequate	*Skills appropriate to level of practice*
S	And giving that bit more that is an attitude isn't it? But that is a personality trait	
B	She can say well fine who is the mug here	
J	But to me the right thing to do is to push yourself and demonstrate and put a little bit more into it and then you are armed with the ?evidence it is up to you to say I am worth a bit more because someone can see that then Are people actually communicating what they are doing? You can get into a dilemma if you are operating beyond the level of your job description so that can be an issue for some people but there are different ways in which you communicate or sell what you are doing in projecting a positive image of whatever the work is which you are doing which is a bit different isn't it? Because someone that works at the bare minimum but you can have someone else working at that level but communicating some sort of enthusiasm for that work so that makes a difference. I am not necessarily talking about working to the next level	*Motivation 'pushing self' expectations of level of competency*
B	But is that enough?	